

07323

7323 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH ANNE ARUNDEL CITY (If outside corporate limits, write RURAL OR and give nearest town) 10 ANNAPOLIS		2. USUAL RESIDENCE (HOME) OF DECEASED 18 N Cherry St STATE MARYLAND COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
3. NAME OF DECEASED (Type or Print) FRANK GEROD BAKER, SR (First) (Middle) (Last)		4. DATE OF DEATH AUG 1 1955 (Month) (Day) (Year)	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) D	8. DATE OF BIRTH MAY 28, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUS MANAGER		10b. KIND OF BUSINESS OR INDUSTRY SERVICES	9. AGE last birthday 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.
11. BIRTHPLACE (State or foreign country) ANNAPOLIS, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN Wm Baker		14. MOTHER'S MAIDEN NAME Estelle Ne Tydings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT & ADDRESS SON, 101 DREAM'S LANDING			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Acute myocardial infarction ANTECEDENT CAUSE(S) DUE TO (B) Coronary artery disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			2 hrs 10 yrs
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Bleeding peptic ulcers			36 yrs.
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8/1/55, 39.57, to 8/3/55, 11.57, 1955, that I last saw the deceased alive on 8/1/55, 1955, end that death occurred at 10:55 M, from the causes end on the date stated above. 21.155 SIGNATURE John R. Hederman M.D. 90 Cathedral St. Annapolis, Md. ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF 8-4-1955	NAME OF CEMETERY OR CREMATORY Asbury Church	LOCATION (City, town, or county) (State) Arnold, Md.
24. REC'D BY REGISTRAR DATE 8-3-1955	REGISTRAR'S SIGNATURE J. O. Daniel	25. FUNERAL DIRECTOR'S SIGNATURE J. L. M. Taylor Son Annapolis, Md.	

VS A15C 1-55 10M

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

03328

MASSACHUSETTS DEPARTMENT OF HEALTH-BOSTON

1955 CERTIFICATE OF DEATH

Form No. 1

1. Name of deceased (Print or type full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Time of death (Hour, minute)

7. Cause of death (Immediate cause)

8. Cause of death (Underlying cause)

9. Cause of death (Contributing cause)

10. Place of death (City, State, Country)

11. Date of funeral (Month, day, year)

12. Signature of physician (Print name)

13. Signature of registrar (Print name)

14. Signature of informant (Print name)

15. Signature of witness (Print name)

16. Signature of physician (Print name)

17. Signature of registrar (Print name)

18. Signature of informant (Print name)

19. Signature of witness (Print name)

20. Signature of physician (Print name)

21. Signature of registrar (Print name)

22. Signature of informant (Print name)

23. Signature of witness (Print name)

24. Signature of physician (Print name)

25. Signature of registrar (Print name)

26. Signature of informant (Print name)

27. Signature of witness (Print name)

28. Signature of physician (Print name)

29. Signature of registrar (Print name)

30. Signature of informant (Print name)

31. Signature of witness (Print name)

32. Signature of physician (Print name)

33. Signature of registrar (Print name)

34. Signature of informant (Print name)

35. Signature of witness (Print name)

36. Signature of physician (Print name)

37. Signature of registrar (Print name)

38. Signature of informant (Print name)

39. Signature of witness (Print name)

40. Signature of physician (Print name)

41. Signature of registrar (Print name)

42. Signature of informant (Print name)

43. Signature of witness (Print name)

44. Signature of physician (Print name)

45. Signature of registrar (Print name)

46. Signature of informant (Print name)

47. Signature of witness (Print name)

48. Signature of physician (Print name)

49. Signature of registrar (Print name)

50. Signature of informant (Print name)

51. Signature of witness (Print name)

52. Signature of physician (Print name)

53. Signature of registrar (Print name)

54. Signature of informant (Print name)

55. Signature of witness (Print name)

56. Signature of physician (Print name)

57. Signature of registrar (Print name)

58. Signature of informant (Print name)

59. Signature of witness (Print name)

60. Signature of physician (Print name)

61. Signature of registrar (Print name)

62. Signature of informant (Print name)

63. Signature of witness (Print name)

64. Signature of physician (Print name)

65. Signature of registrar (Print name)

66. Signature of informant (Print name)

67. Signature of witness (Print name)

68. Signature of physician (Print name)

69. Signature of registrar (Print name)

70. Signature of informant (Print name)

71. Signature of witness (Print name)

72. Signature of physician (Print name)

73. Signature of registrar (Print name)

74. Signature of informant (Print name)

75. Signature of witness (Print name)

76. Signature of physician (Print name)

77. Signature of registrar (Print name)

78. Signature of informant (Print name)

79. Signature of witness (Print name)

80. Signature of physician (Print name)

81. Signature of registrar (Print name)

82. Signature of informant (Print name)

83. Signature of witness (Print name)

84. Signature of physician (Print name)

85. Signature of registrar (Print name)

86. Signature of informant (Print name)

87. Signature of witness (Print name)

88. Signature of physician (Print name)

89. Signature of registrar (Print name)

90. Signature of informant (Print name)

91. Signature of witness (Print name)

92. Signature of physician (Print name)

93. Signature of registrar (Print name)

94. Signature of informant (Print name)

95. Signature of witness (Print name)

96. Signature of physician (Print name)

97. Signature of registrar (Print name)

98. Signature of informant (Print name)

99. Signature of witness (Print name)

100. Signature of physician (Print name)

101. Signature of registrar (Print name)

102. Signature of informant (Print name)

RECEIVED

BUREAU V. S.

AUG 4 1955

RECEIVED

7324 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Md		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN 10 Annapolis		3 days		TOWN Annapolis, Md. (Arundel) 10			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 57 USNH, Annapolis, Md				STREET ADDRESS (If rural give location) USNH, Annapolis, Md.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Kenneth (Middle) Charles (Last) BAKER				(Month) August (Day) 5 (Year) 19 55			
5. SEX M	6. COLOR OR RACE Cau.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH 3 August 1955	9. AGE last birthday yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
				Months 3 Days 3		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles Ernest BAKER				14. MOTHER'S MAIDEN NAME Ana Marie RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT & ADDRESS USNH, Annapolis, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 days	
762.5 IMMEDIATE CAUSE (A) Atelectasis with immaturity # 762.5							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-3, 19-55, to 8-5, 19-55, that I last saw the deceased alive on 8-5, 19-55, and that death occurred at 1:15 AM, from the causes and on the date stated above.							
SIGNATURE E.R. PETERS LT MC USN				ADDRESS (Street, city, town, state) M.D. USNH, Annapolis, Maryland		DATE SIGNED 5 Aug. 1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug 8, 1955		NAME OF CEMETERY OR CREMATORY Naval Cemetery		LOCATION (City, town, or county) Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE August 8, 1955				Hopping Funeral Home		Annapolis, Md.	

21 85211302

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE AISC 1-55 10M

CERTIFICATE OF DEATH

1

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Report		Date of Entry		Date of Filing	

BUREAU V. S.

AUG 10 1925

RECEIVED

7325 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN		TOWN	
14 TOWN <u>Annapolis</u>		Years		Annopolis		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hosp.</u>				STREET ADDRESS (If rural give location)			
63				813 Bay Ridge Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
DAVID COOKE BANKERT				Aug. 24. 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	Aug. 19, 1886	69 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
manager		hotel		Westminster, Md.		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
David J. Bankert				Rachel Cole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		no		Md.			
		219-07-9608		Elizabeth G. Bankert, Annapolis.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				3 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				10 yrs.			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				5 days			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
8/17/55		ruptured appendix & abscess & localized peritonitis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 19, 1955</u> to <u>Aug 24, 1955</u> , that I last saw the deceased alive on <u>Aug 24, 1955</u> , and that death occurred at <u>2:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>J. B. Borsini</u>		<u>Annapolis Md</u>		<u>8/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
burial		8/27/55		Pipe Creek Cemetery		Carroll county, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Aug. 29, 1955</u>		<u>Wm. J. French</u>		<u>10.10 Hawthorne St.</u>		<u>Union Bridge Md.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1955 CERTIFICATE OF DEATH

Blank form area for death certificate details.

BUREAU V. S.

AUG 29 1955

RECEIVED

NOTIFICATION OF DEATH TO BE FURNISHED TO THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, DIVISION OF VITAL RECORDS, BY THE REGISTRAR OF DEATHS, COUNTY OF [] STATE OF []

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7353

07326

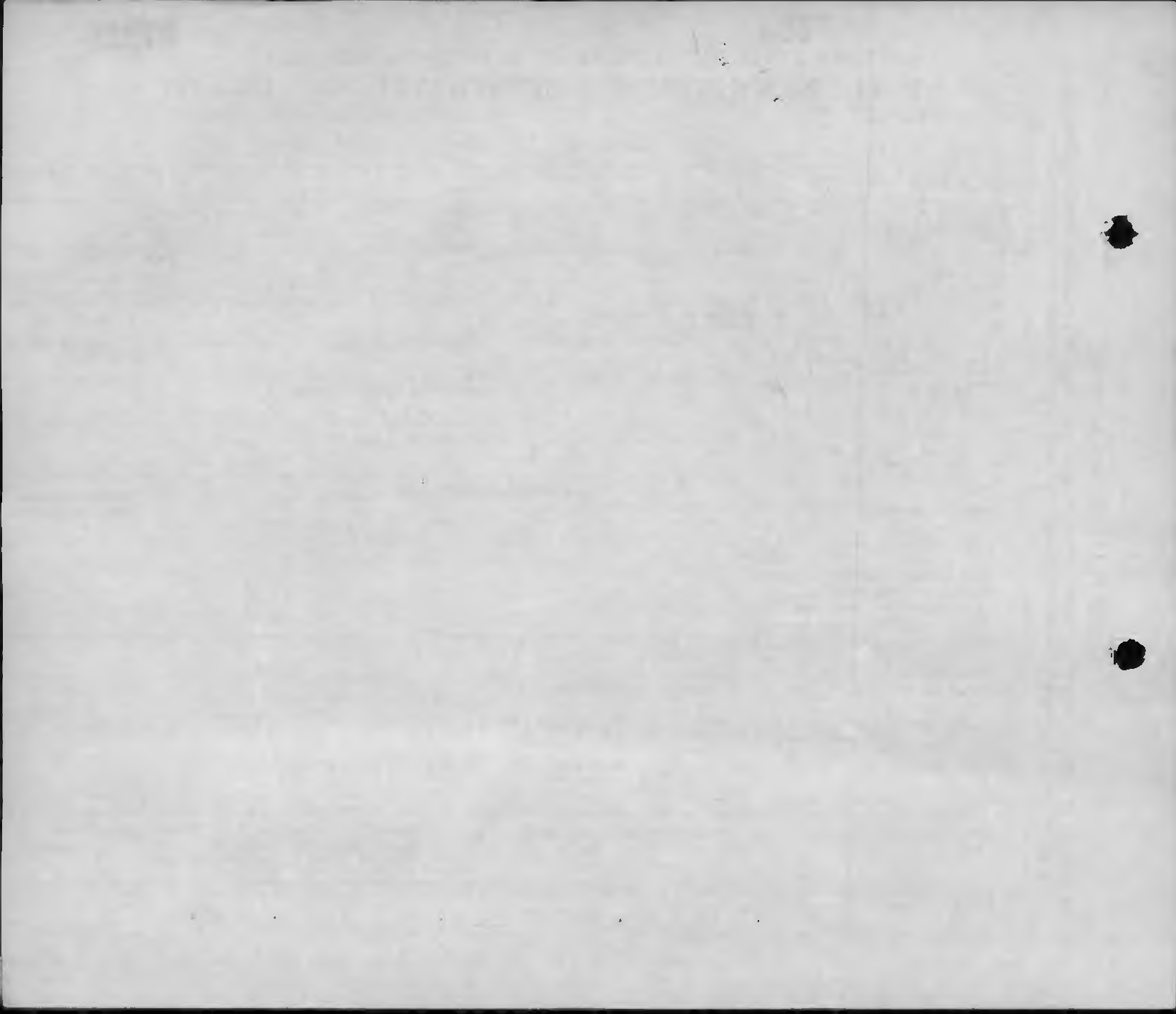
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. *3401-4*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Md.</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Severna Park</i>	LENGTH OF STAY (In this place) <i>4 months</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Old Annapolis Rd.</i>		STREET ADDRESS (If rural, give location) <i>1213 21. Landow St</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Charles H.</i> (Middle) <i>Bennett</i> (Last)		(Month) <i>August</i> (Day) <i>30</i> (Year) <i>1955</i>	
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>Caucasian</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>Widowed</i>	8. DATE OF BIRTH: <i>4/4/86</i>
9. AGE last birthday: <i>69</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Retired Police</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Steven Bennett</i>		14. MOTHER'S MAIDEN NAME: <i>Sarah Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>217-07-2234</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Mrs. Edith Edmonds (niece)</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <i>420.1 Coronary Occlusion</i>		<i>1 week</i>	
DUE TO			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last			
DUE TO			
(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Harold H. Paubert MD</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>8/30/55</i>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>Sept. 3, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
DATE REC'D BY LOCAL REG. <i>Sept 1, 1955</i>		24. FUNERAL DIRECTOR <i>Mrs. Katie R. Williams</i>	
REGISTRAR'S SIGNATURE <i>C. W. Hedrick</i>		ADDRESS <i>322 Schroeder St</i>	



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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07327

7354 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Glen Burnie</u>				TOWN <u>Glen Burnie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>412 N Street SE</u>				STREET ADDRESS (If rural give location) <u>421 N. Street SE</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>ROSS A BENNINGTON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 20, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 23, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburgh, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James William Bennington</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Ashcraft</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>		16. SOCIAL SECURITY NO. <u>208-01-2901</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth Bennington- wife- same as #2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 1952</u> to <u>Aug. 1955</u> , that I last saw the deceased alive on <u>8-18</u> , 19 <u>55</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. MacDonald</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie Md</u>		DATE SIGNED <u>8-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 23, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Aug-22-1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kipper Funeral Home</u>		ADDRESS <u>Glen Burnie, Md.</u>	

100-333

WASHINGTON STATE DEPARTMENT OF HEALTH - BATTLE ROSE 32

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

BUREAU V. S.

AUG 22 1933

RECEIVED

RECEIVED

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BATTLE ROSE, WASHINGTON. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BATTLE ROSE, WASHINGTON. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BATTLE ROSE, WASHINGTON.

1 **TO ATTENDING PHYSICIAN-OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A15C 1-51 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7355

CERTIFICATE OF DEATH

07328

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>North Carolina</u>		COUNTY <u>Lenoir</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Port G. G. Meade,</u>		24 Months		Kinston		70 X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 <u>U. S. Army Hospital</u>				1057 Waters Street ✓			
3. NAME OF (First) (Middle) (Last) <u>BEST</u>				4. DATE OF DEATH (Month) (Day) (Year)			
(Type or Print) <u>DEMETRIUS ELIAS</u>				<u>August 18</u> 19 <u>55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>August 18, 1955</u>		9. AGE last birthday yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u>	IF UNDER 24 HRS.<!--</b--> Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeane R. Best</u>				14. MOTHER'S MAIDEN NAME <u>Zelma Lee Robbitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, Apt. B 306 Suter Road Baltimore 28, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
77' X IMMEDIATE CAUSE (A) <u>Prematurity</u>				<u>Prematurity</u>		<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 August 1955</u> to <u>18 August 1955</u> that I last saw the deceased <u>alive on</u> <u>18 Aug 55</u> and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>HERBERT L. NEEDLEMAN</u>		M.D. <u>1st Lt. MC</u>		ADDRESS (Street, city, town, state) <u>Fort G. G. Meade, Md. 18 Aug 55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>18 August 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		LOCATION (City, town, or county) (State) <u>Fort G.G. Meade, Maryland</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>CHAPLAIN QUIGLEY</u>		ADDRESS <u>Fort G.G. Meade, Md.</u>	
DATE <u>18 August 1955</u>							

THREAT V. S.

AUG 2

REC-1

7356

CERTIFICATE OF DEATH

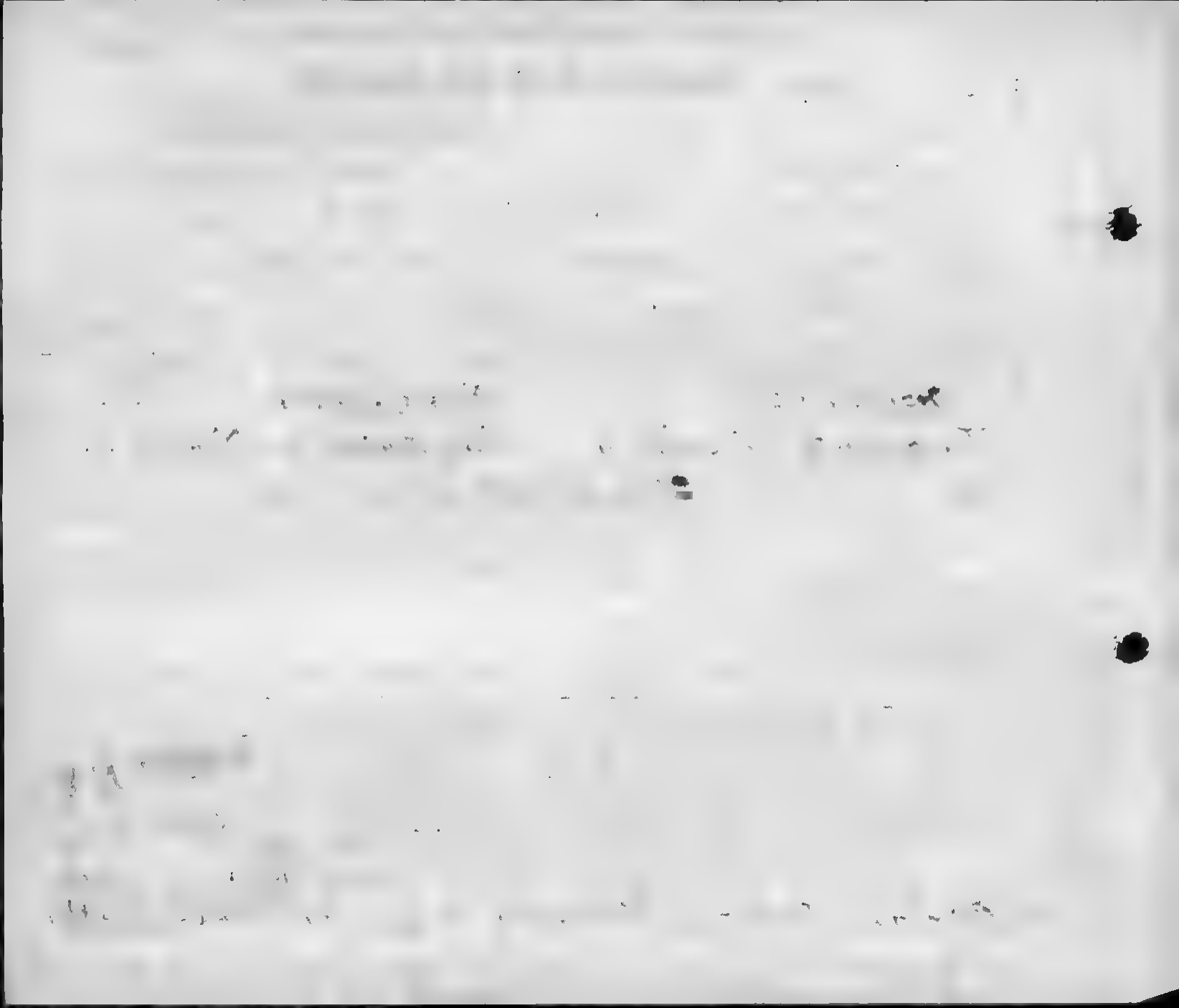
Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		<u>8 mos. 25 days</u>		TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>212 Clay Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Emma R. Boston</u>				<u>8 18 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Female</u>	<u>Negro</u>	<u>Single</u>	<u>Unknown</u>	<u>67 1/2</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME <u>Thomas Boston</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Makell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-14-8125</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Acute Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Cerebro Vascular Accident</u>						<u>Since 8/6/55</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/24</u>, 19 <u>54</u>, to <u>8/18</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>8/18</u>, 19 <u>55</u>, and that death occurred at <u>12:05 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>(L. Benedict)</u>				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>8/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>ANNA POLIS, Md</u>	
24. REC'D BY REGISTRAR <u>Aug 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Lothar M. Jurek</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u>		ADDRESS <u>108 W. Wash. St Annapolis, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.



07330

7326

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MD</u> COUNTY <u>AA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> MD		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> MD	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place)		TOWN <u>ANNAPOLIS</u>		STREET ADDRESS (If rural give location) <u>82 MARKET ST</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOMELAND CONVALESCENT HOME</u>				STREET ADDRESS (If rural give location) <u>82 MARKET ST</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARY ANN BOUCHER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8-14-1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>11-10-1864</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>JOSEPH BOUCHER</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>John Boucher (2)</u>	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Cerebral arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 19-15, to 8/14, 1955</u> , that I last saw the deceased alive on <u>8/14, 1955</u> , and that death occurred at <u>4:59 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Beck</u>		M.D. <u>4 Southgate Ave Annapolis</u>		DATE SIGNED <u>8/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. REC'D BY REGISTRAR <u>John M. Vayler</u>		REGISTER'S SIGNATURE <u>John M. Vayler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Vayler</u>		ADDRESS <u>Annapolis Md</u>	
DATE <u>Aug 16, 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 7 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

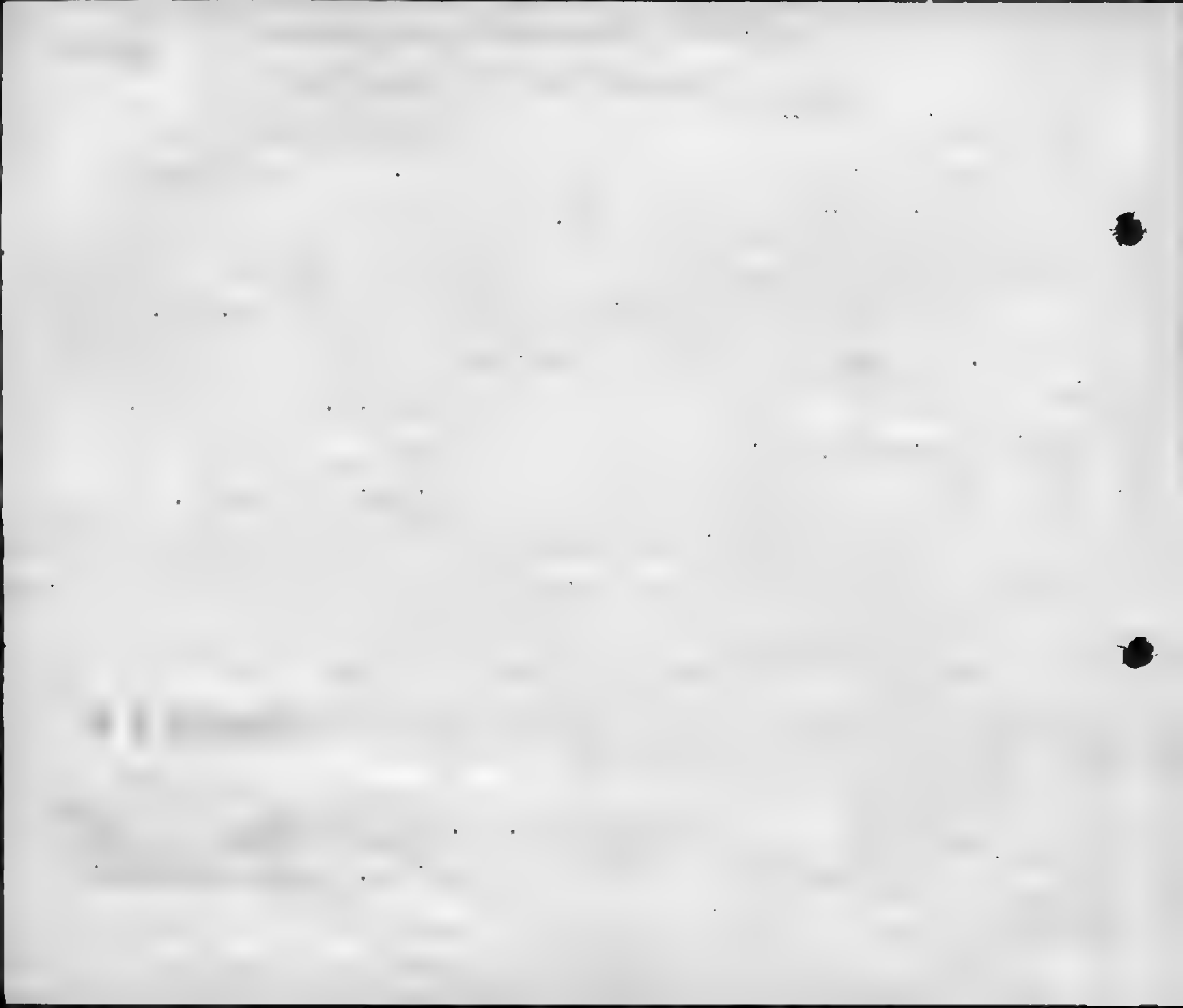
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07331

7357 **CERTIFICATE OF DEATH**

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Millersville</u>		LENGTH OF STAY (In this place) <u>2 months.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Newport</u>		<u>08X-2</u>	
HOSPITAL OR INSTITUTION <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u></u>			
STREET ADDRESS <u></u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John</u> (Middle) <u>Bowling</u> (Last) <u></u>				(Month) <u>Aug.</u> (Day) <u>21st.</u> (Year) <u>19 55</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Washington B. Bowling</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Higgs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sann's Nursing Home Records.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				15. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <u>Diabetes Millitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Over 3 1/2 Months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Paralysis Agitans</u>				<u>Over 3 1/2 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/13/55</u> , 19 <u>55</u> , to <u>8/21/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/19/55</u> , 19 <u>55</u> , and that death occurred <u>5:15 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Christian K. Paubert</u>				ADDRESS (Street, city, town, state) <u>M. D. Glen Burnie, Md.</u>		DATE SIGNED <u>8/21/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-22-55</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Deer Hill, Md.</u>	
24. REC'D BY REGISTRAR <u>8/22/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt + Ryan</u>		ADDRESS <u>Walling, Md.</u>	



7327

MARYLAND STATE DEPARTMENT OF HEALTH

07332

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

Item 9, Film 9187 10-14-55 et

1. PLACE OF DEATH - COUNTY A A		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MD COUNTY A A	
CITY (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		CITY (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8 MARYLAND AVE.		STREET ADDRESS (If rural, give location) 8 MARYLAND AVE.	
3. NAME OF DECEASED (Type or Print) BERTHA		4. DATE OF DEATH (Month) 8 (Day) 31 (Year) 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH July 29 - 1878 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Texas	
13. FATHER'S NAME Bartley Blueclard Bradley		14. MOTHER'S MAIDEN NAME Adeline Elizabeth Newman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Frank V. Rigler 270 King Lee St. Annapolis, MD.	

III. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4. Immediate cause Arteriosclerosis Generalized		
Antecedent cause(s) Disease of conditions, if any, giving rise to the above cause, stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.		
SIGNATURE [Signature] (Degree or title)		DATE SIGNED 9/31/55
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY St. Lincoln LOCATION (City, town, or county) Prince Georges Co. Md.
DATE REC'D BY LOCAL REG. Sept. 1, 1955	REGISTERING PHYSICIAN'S SIGNATURE [Signature]	24. FUNERAL DIRECTOR John M. Taylor, Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

WILLIAM V. S.

SEP 2

100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7350
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07333
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN</u> <u>RURAL</u>		LENGTH OF STAY (in this place) —		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3201-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Delmont Road Severn, Maryland</u>				STREET ADDRESS (If rural, give location) <u>2208 Wilkens Ave.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
<u>WILLIAM H.</u>		<u>BRUCEY</u>		<u>Brucey</u>		<u>Aug. 2 19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>MAY 7, 1936</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Houseman</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u>	
13. FATHER'S NAME: <u>WILLIAM D. BRUCEY</u>				14. MOTHER'S MAIDEN NAME: <u>CATHERINE A. CHRONISTER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY No.: <u>212-34-1168</u>		17. INFORMANT & ADDRESS: <u>CATHERINE BRUCEY 2208 WILKENS AVE</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>981X</u> Immediate cause (a) <u>Gunshot wound of chest with bilateral massive hemothorax and gunshot injury of heart</u> Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY) <u>road</u>		21c. (City or town) (County) (State) <u>Severn Anne Arundel Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8/2/55 12:10 A.M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Shot while stealing gasoline</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Timothy J. Men</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>Aug. 2, 1955</u> M. D.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>8-5-55</u>		NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, Md</u>	
DATE RECD BY LOCAL REG <u>8-5-55</u>		REGISTRAR'S SIGNATURE <u>J. V. H. [unclear]</u>		24. FUNERAL DIRECTOR <u>George L. Schuman</u>		ADDRESS <u>2101 Frederick Ave Balco., Md</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07335

7328

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 N. Cherrygrove Ave</u>				STREET ADDRESS (If rural give location) <u>7 N. Cherrygrove Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>JOSPHINE M CALLAHAN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 21, 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>March 13, 1872</u>	
				9. AGE last birthday <u>83 yrs.</u>		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Havre De Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MARDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs J. Bernard Vallandingham, same as 2</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>4221</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardio Vascular Disease - 4221</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 22, 1955, to August 20, 1955, that I last saw the deceased alive on Aug 21, 1955, and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Thannie Klamms M.D.</u>				DATE SIGNED <u>8/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Francis Cemetery</u>		LOCATION (City, town, or county) (State) <u>Abingdon, Maryland</u>	
24. REC'D BY REGISTRAR <u>Aug 23, 55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			
DATE <u>Aug. 23, 55</u>				ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

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MARYLAND

7359

07336

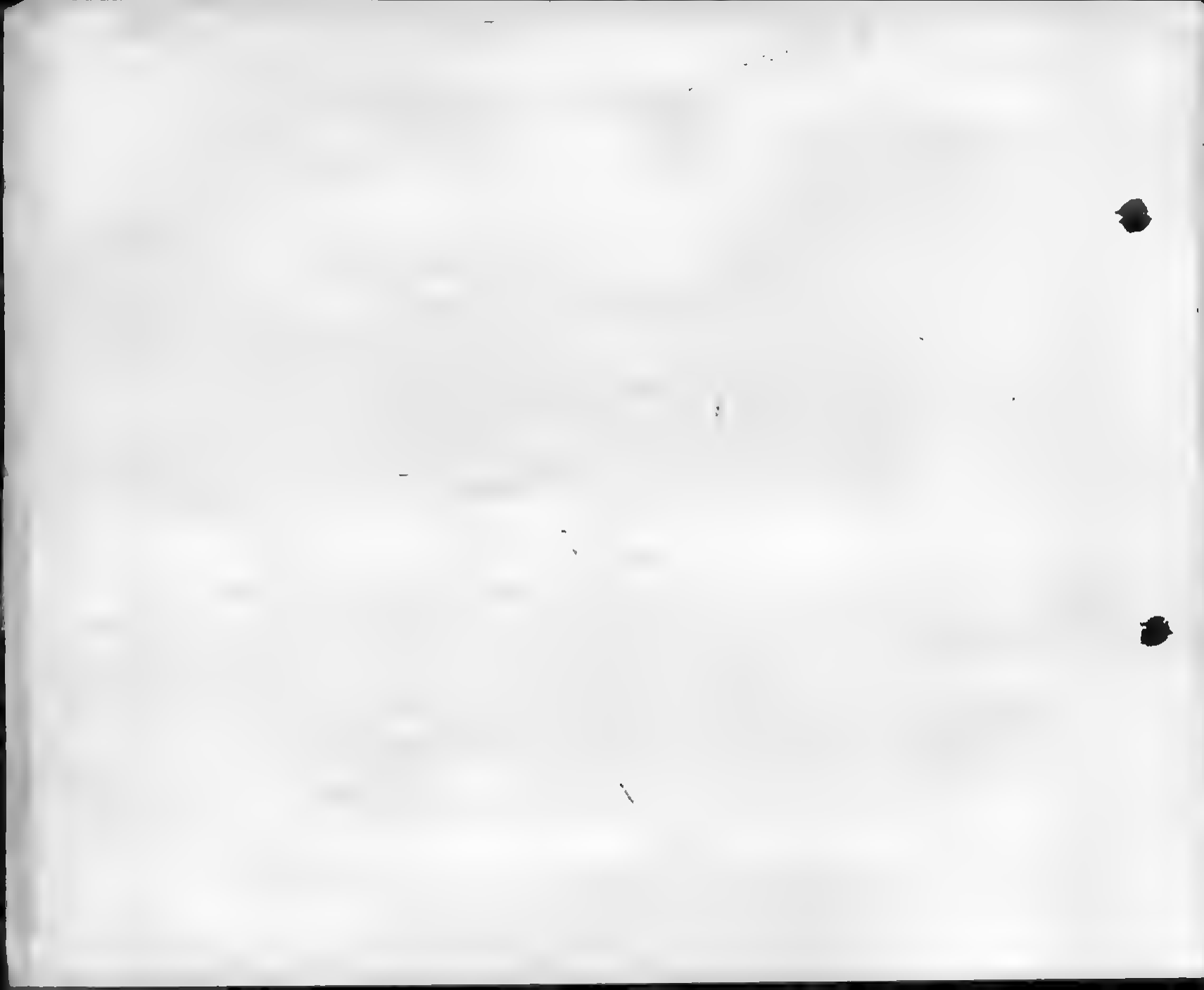
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural. Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cor. Old Line of Police Bldg. Ritchie Highway</u>				STREET ADDRESS (If rural, give location) <u>Cor. Old Line of Police Bldg. Ritchie Highway</u>			
3. NAME OF DECEASED (Type or Print) <u>Anna Fitzgerald CAUFFMAN.</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>Aug. 2</u> 19 <u>55</u> (Month) (Day) (Year)			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>14 Dec 1905</u> 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waitress & Housewife. Restaurant.</u>				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday Under 1 year If under 24 hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Sylvester Staylor</u>				14. MOTHER'S MAIDEN NAME <u>Margaret O'Neil</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No. <u>-</u>			
17. INFORMANT AND ADDRESS <u>Husband - LeRoy Cauffman, Park, Severna</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>427.1</u> Immediate cause (a) <u>MYOCARDIAL INFARCTION (Multiple)</u> Antecedent cause(s) <u>Coronary Sclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>HYPertensive Cardio-Vascular Disease</u> (c) <u>Disease</u>						5 yrs. 10 yrs.	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>APRIL 19 55</u> to <u>2 Aug. 19 55</u> , that I last saw the deceased alive on <u>1 Aug. 19 55</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hahn</u>		(Degree or title)		ADDRESS <u>Severna Park Md.</u>		DATE SIGNED <u>2 Aug. 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>buried</u>		<u>Aug 5 1955</u>		<u>Bellevue Hill</u>		<u>U.S.A.</u>	
DATE REC'D BY LOCAL REG. <u>8-3-55</u>		REGISTRAR'S SIGNATURE <u>R. W. Hahn</u>		24. FUNERAL DIRECTOR <u>C. J. Hahn</u>		ADDRESS <u>1414 N. ...</u>	

NOT TO BE REPRODUCED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7360

CERTIFICATE OF DEATH

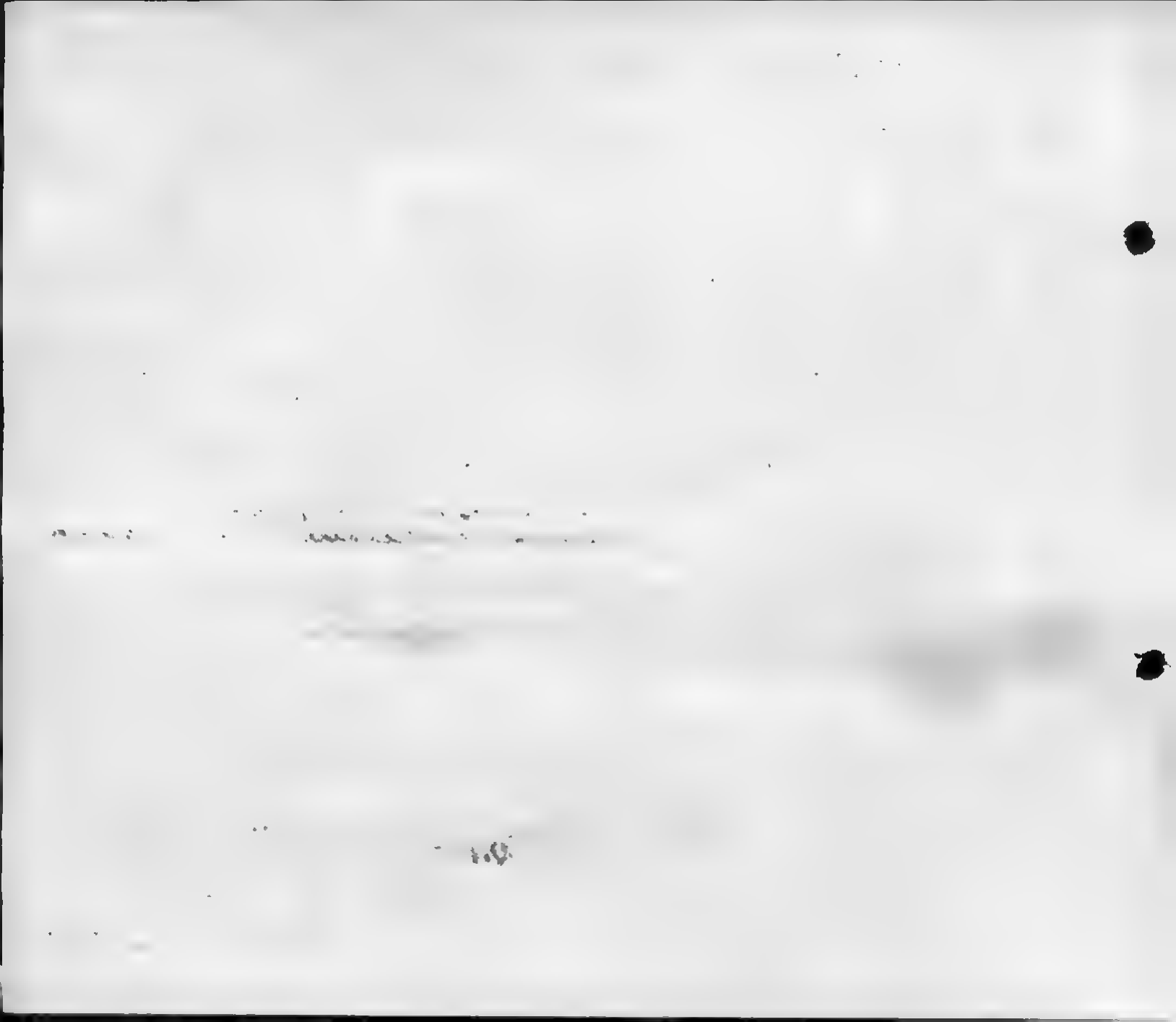
Reg. Dist. No.

07337

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>AA</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN near Gibson Island</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rocky Beach Farm</u>	MARYLAND LENGTH OF STAY (In this place)	STATE <u>Maryland</u> COUNTY <u>East</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Baltimore 12</u> STREET ADDRESS (If rural give location) <u>6416 Pinehurst Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Thomas S. Cassedy</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>August 1, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>September 21, 1904</u> 50 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engr.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Consulting</u>	
11. BIRTHPLACE (State or foreign country): <u>Gloversville, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward K. Cassedy</u>		14. MOTHER'S MAIDEN NAME: <u>Capitola Bowen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Alice C. Cassedy, 6416 Pinehurst Road</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.1</u>		<u>1955</u>	
ANTECEDENT CAUSE (S)		<u>1954</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>1954</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.) OF INJURY	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 1, 1955</u> to <u>Aug 1, 1955</u> , that I last saw the deceased alive on <u>Aug 1, 1955</u> , and that death occurred at <u>12:09 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ag 1</u>		DATE SIGNED	
M. D. <u>S. R. Bishop</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 3, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug 3 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. Tucker & Sons, Balto. 17, Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7329

CERTIFICATE OF DEATH

07338

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNA POLIS</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNA POLIS</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>ANNA POLIS</u>				OR TOWN <u>ANNA POLIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. General Hosp.</u>				STREET ADDRESS (If rural give location) <u>1940 West Street</u>			
3. NAME OF DECEASED (Type or Print) <u>William Henry Colbert Jr.</u>				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>4-1-1955</u>	
9. AGE last birthday yrs. <u>4</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Colbert</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>William Colbert Jr., 1940 West St ANNA POLIS</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
571.5 IMMEDIATE CAUSE (A) <u>Intestinal Obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-7-55</u> to <u>8-7-55</u>, that I last saw the deceased alive on <u>8-7-55</u>, 19<u>55</u>, and that death occurred at <u>7</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. T. Colbert</u>		M.D. <u>W. T. Colbert</u>		ADDRESS (Street, city, town, state) <u>108 W. Wash. St ANNA POLIS, Md.</u>		DATE SIGNED <u>8-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>8-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Nope Chapel</u>		LOCATION (City, town, or county) <u>EDGEWATER, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II</u>		ADDRESS	
DATE <u>Aug 9, 1955</u>							

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MS AHC 1-55 10H

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

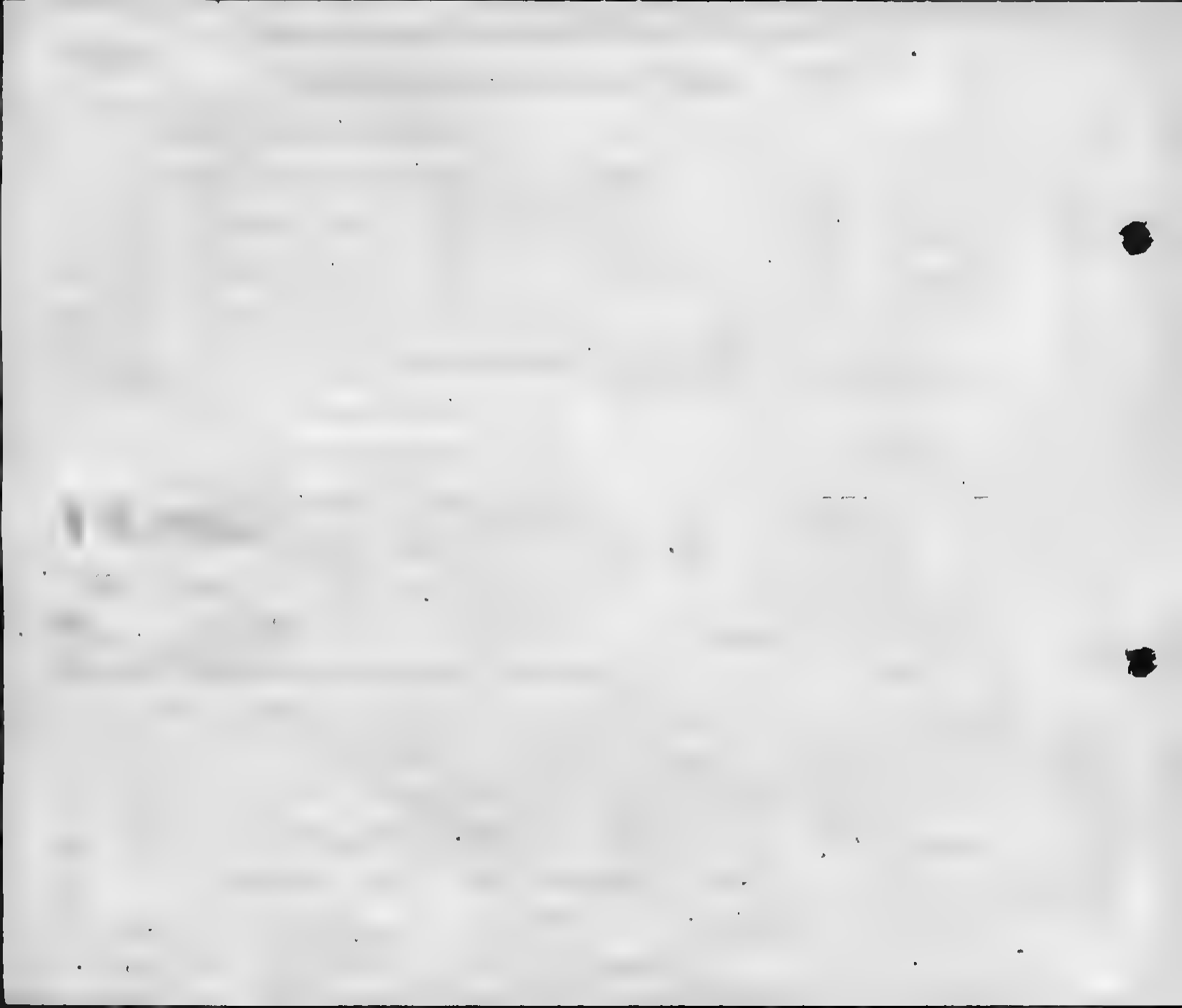
7330

CERTIFICATE OF DEATH

07339

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)		1	
<u>Anne Arundel General Hospital</u>				<u>76 East Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>NATHAN COOPER</u>				<u>August 30, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>March 8, 1890</u>	<u>65 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Tailor</u>		<u>Custom tailor shop</u>		<u>Poland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Morris Cooper</u>				<u>Sadie Diamond</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>?</u>		<u>Mrs Anna Cooper- same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
581.0 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>Be. Cardiac dilatation & Pulmonary edema</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				<u>Curiosis of liver & ascites, etc</u>			
				<u>1 yr.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Maurice Klamans, M.D.</u>				<u>Annapolis, Md</u>		<u>8/31/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>September 1, 55</u>		<u>Montiflore Cemetery</u>		<u>Philadelphia, Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Sept. 1, 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

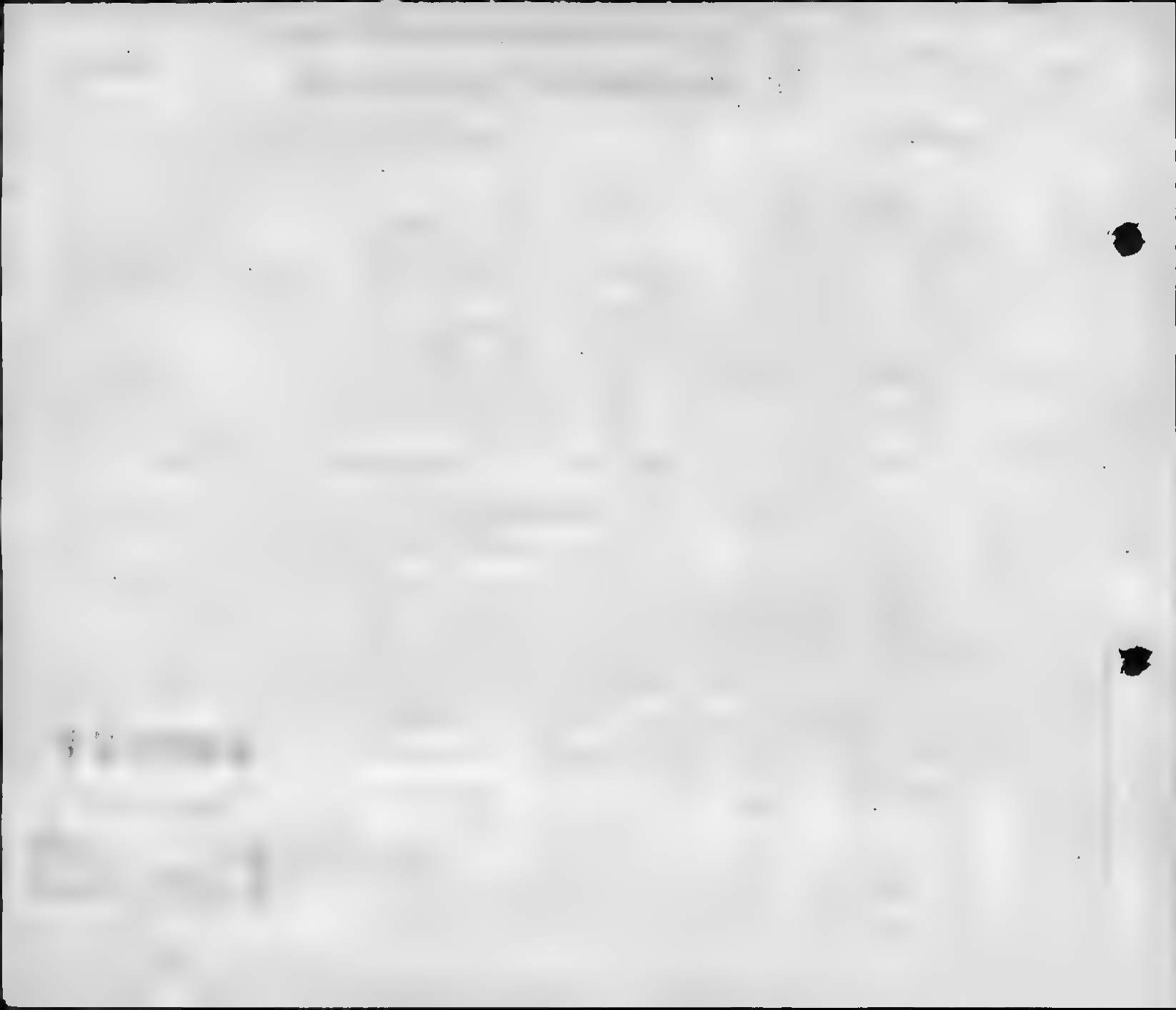
7361

CERTIFICATE OF DEATH

07340

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>3 yrs</u>		TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>120 Marie Ave., N.E.</u>				STREET ADDRESS (If rural give location) <u>120 Marie Ave., N.E.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Rheba M. Coplin</u>				<u>August 5, 1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct-13, 1892</u>	
9. AGE last birthday <u>62</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>120 Marie Ave. Glen Burnie, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-</u> , 19 <u>53</u> , to <u>8-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-4-55</u> , 19 <u>55</u> and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. MacDonald M.D.</u>		M.D. <u>Isabel Burnie M.D.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>8-5-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 8, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR <u>Aug. 6, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Vignitto</u>		ADDRESS <u>Glen Burnie Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

• 7331

07341

Reg. Dist. No. 21

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY A. A. County		MARYLAND		STATE Maryland COUNTY A.A.			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN Annapolis		Transient		TOWN Drury, Maryland			
HOSPITAL OR D.O. A. Anne Arundel General Hospital				STREET ADDRESS (If rural, give location) Wayson's Corner.			
INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED: (Type or Print)			(First) Cleve	(Middle)	(Last) CRINER	4. DATE OF DEATH (Month) 8 (Day) 26 (Year) 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: --		9. AGE last birthday: 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Sawmill		11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Clarence Criner				14. MOTHER'S MAIDEN NAME: Alice Sheldon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W.II.		16. SOCIAL SECURITY No.: --		17. INFORMANT & ADDRESS: Mrs. Pauline O'Neal West River, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
9103 Immediate cause		(a) DUE TO Internal Shock - due to					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b) DUE TO Internal Injuries					
		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town, (County)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8 26 55 1 P.M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? He fell on subject			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE Ben R. [Signature]		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. 8/26/55					
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF Aug. 27, 1955		NAME OF CEMETERY OR CREMATORY Vaughan-Guynn Funeral Home		LOCATION (City, town, or county) (State) Galax, Va.	
DATE REC'D BY LOCAL REG. Aug. 30, 1955		REGISTRAR'S SIGNATURE Wm. J. French		24. FUNERAL DIRECTOR Ritchie Bros. Funeral Home		ADDRESS Upper Marlboro, Md.	

BUREAU V

SEP 1 1955

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INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

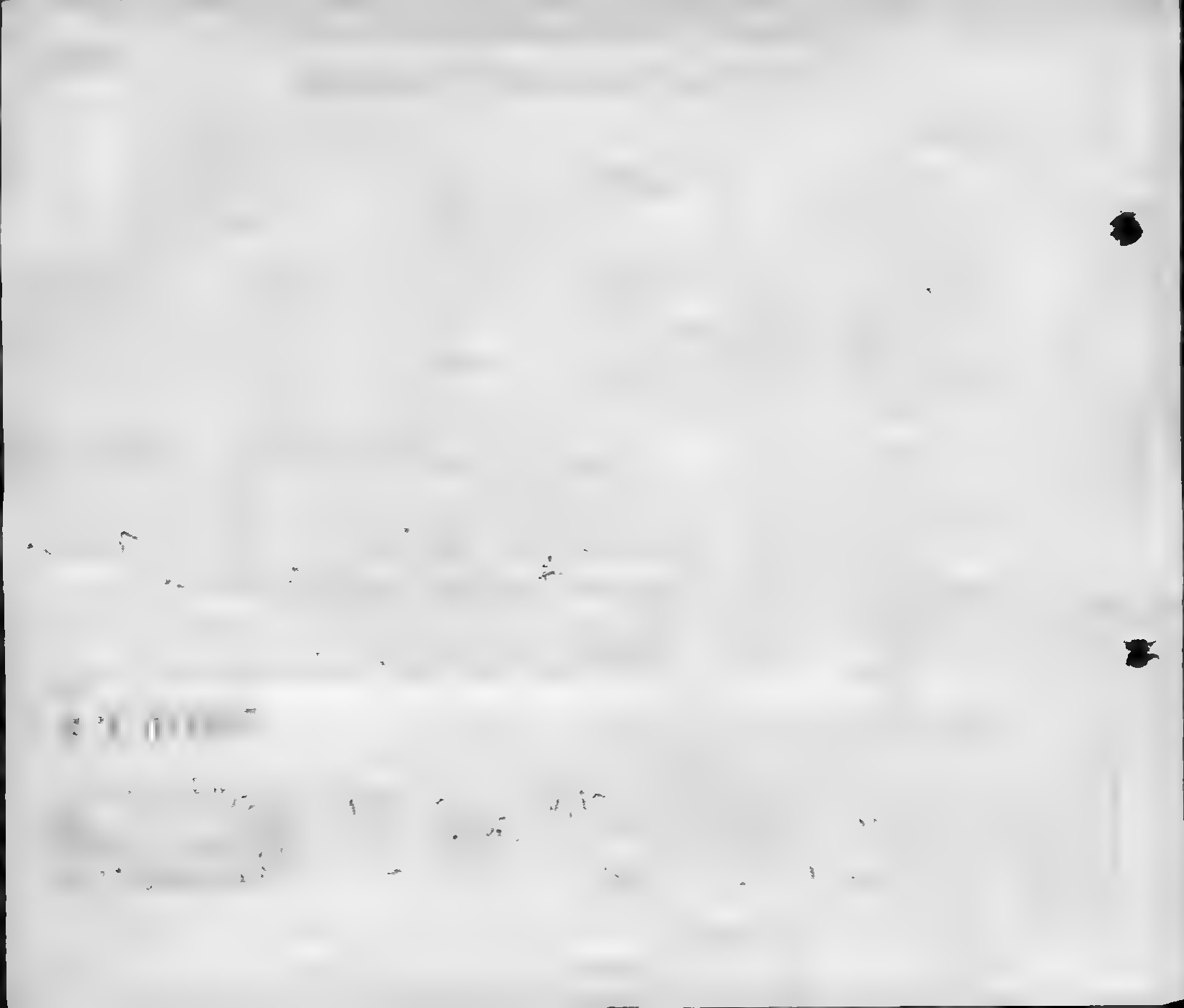
7332

CERTIFICATE OF DEATH

07342

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>				STATE <i>Maryland</i> COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel General</i>				STREET ADDRESS (If rural give location) <i>111 Academy St.</i>			
3. NAME OF DECEASED (Type or Print) <i>Caroline</i> (First) <i>Davis</i> (Middle) <i>Davis</i> (Last)				4. DATE OF DEATH (Month) <i>Aug.</i> (Day) <i>1</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widow</i>	8. DATE OF BIRTH <i>March 29, 1874</i>	9. AGE last birthday <i>81</i> yrs.	10. UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Edward Spriggs</i>				14. MOTHER'S MAIDEN NAME <i>Mary Frances</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no; or unk.) <i>No</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>10</i>		17. INFORMANT & ADDRESS <i>Mrs. J. J. Stetile #2</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>7 days.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Cerebral & general arteriosclerosis.</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Stroke</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>7/14</i> , 19 <i>55</i> , to <i>8/1</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>8/1</i> , 19 <i>55</i> , and that death occurred at <i>5:45</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Mamie K. Krawans</i> M.D.				ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>8-3-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Asbury Meth. dist</i>		LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. J. Stetile</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>1015 Chesapeake St.</i>	
DATE <i>8-3-1955</i>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08326

Item 7, Fil-G-1-9-1-55 at

7362

CERTIFICATE OF DEATH

Reg. Dist. No.

22

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>LAUREL</u>	<u>5 months</u>	TOWN <u>LAUREL, MARYLAND</u>	<u>Wash. D.C.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<u>District Training School</u>		<u>1006 N. St. N. District Training School</u>	<u>47 x 3</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>Stanley - DEAN</u>		<u>August 28 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>MALE</u>	<u>NEGRO</u>	<u>Single</u>	<u>July 3, 1953</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>2 yrs.</u>		<u>WASHINGTON, D.C.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>NATHANIEL TAYLOR</u>		<u>GEORGIA MAE DEAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>No</u>		<u>None</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<u>20 days</u>	
IMMEDIATE CAUSE (A) <u>INANITION</u>			
ANTECEDENT CAUSE (B) <u>Intestinal Toxemia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) <u>HYDROCEPHALIC Idiot</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>0</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 8, 1955</u> , to <u>Aug 28, 1955</u> that I last saw the deceased alive on <u>Aug 28, 1955</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		ADDRESS	DATE SIGNED
<u>Margaret Wong Molar</u>		<u>M. D. District Training School</u>	<u>8-28-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>Aug 31-55</u>	<u>District Training School</u>	<u>Laurel, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>Aug 28-55</u>	<u>Elaine Hoaslop</u>	<u>Melvin Melvin</u>	<u>Washington</u>



MARYLAND

7363

07343

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>U. D. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>5A-2nd Ave.</u> COUNTY <u>J. D. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater P.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Marley Heights</u>	
TOWN <u>Edgewater P.D.</u>		TOWN <u>Marley Heights</u>	
HOSPITAL OR INSTITUTION OF STREET ADDRESS <u>None</u>		STREET ADDRESS <u>5A-2nd Ave - Marley Heights</u>	
3. NAME OF DECEASED (Type or Print) <u>Elbert</u> (First) (Middle) (Last) <u>Dupski</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 10, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH (Month) (Day) (Year) <u>9/3/32</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>22</u> yrs. <u>11</u> months <u>8</u> days <u>4</u> min.
11. BIRTHPLACE (State or foreign country) <u>Austria - Carste</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>Stephens Fitz</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Nicholas J. Dupski, 3940 Brooklyn Avenue</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a).....		Coronary Thrombosis		Immediate	
Antecedent cause(s) (b).....		arteriosclerosis - Cardio-Vascular Disease		1 yr.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....		None			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>11/20/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fall - blood vessel disease</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>Suicide</u>		PLACE (If home, farm, factory, street, office bldg., etc.) <u>Home</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) <u>11/20/55</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5/9, 1955, to 8/10/55, that I last saw the deceasedalive on 8/10/55, 1955, and that death occurred at 11:00 m. from the causes and on the date stated above.SIGNATURE Dr. Fredrickson (Degree or title) ADDRESS 45 South Green Street, Wash. D.C. DATE SIGNED 8/10/55

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>August 13, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	LOCATION (City, town, or county, State) <u>Brooklyn, Maryland</u>
DATE REC'D BY LOCAL REG. <u>Aug 11, 1955</u>	REGISTRAR'S SIGNATURE <u>U. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons, Batts. 17, Md.</u>	

MARGIN RESERVED FOR BINDING

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate should be detached for use as a burial transit permit.

8332

CERTIFICATE OF DEATH

22

Item 9, Film G187 9-28-55 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Severn</i>				TOWN <i>Severn</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Camp Meade Road</i>				STREET ADDRESS (If rural give location) <i>Camp Meade Road</i>			
3. NAME OF DECEASED (Type or Print) <i>Henrietta - Durner</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>8 28 19 55</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Oct. 16, 1877</i>	
9. AGE last birthday <i>617 77 yrs.</i>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Basil Griffith</i>				14. MOTHER'S MAIDEN NAME <i>Emily Hawkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Mr. Wesley Durner, Severn, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>332X IMMEDIATE CAUSE (A) CEREBRAL THROMBOSIS</i>						<i>1 wk.</i>	
2. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>CEREBRAL ARTERIOSCLEROSIS</i>						<i>4 yrs.</i>	
3. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>-</i>						<i>-</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>SEPT. 8-27, 19 55</i> to <i>AUG 28, 19 55</i>, that I last saw the deceased alive on <i>8-27, 19 55</i>, and that death occurred at <i>1:40 AM</i>, from the causes and on the date stated above.							
SIGNATURE <i>Leon C. Perry</i>				DATE SIGNED <i>M.D. 201 B + A Blvd GLEN BURNIE MD. 8-31-55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 1, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>	
24. RECD BY REGISTRAR <i>Sept 7-55</i>		REGISTRAR'S SIGNATURE <i>Clara Heaslip</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. R. Singleton</i>		ADDRESS <i>Glen Burnie, Md.</i>	



7364

07344

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

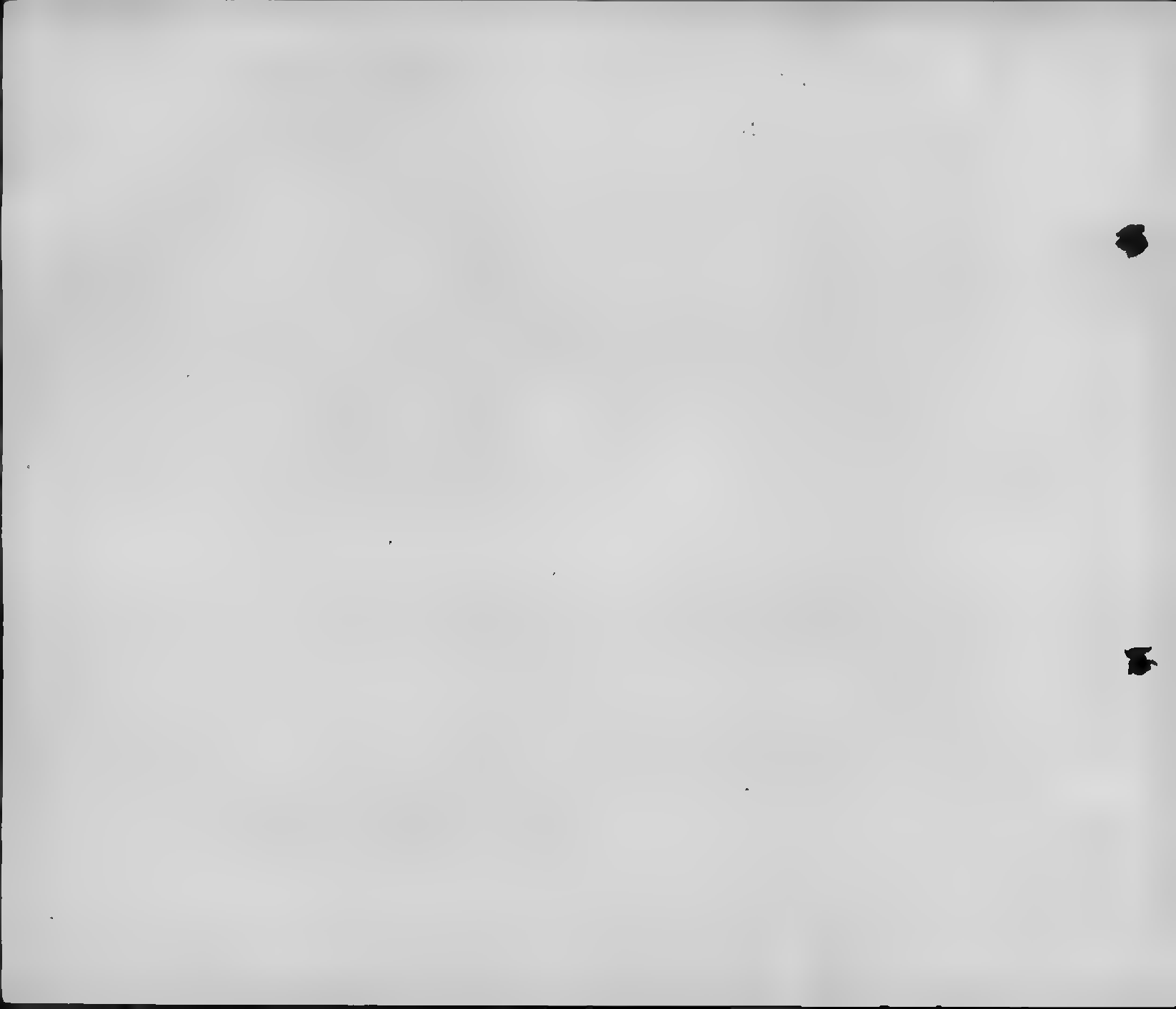
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE D. C.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Fort Meade	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Washington	16x-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fort Meade		STREET ADDRESS (If rural, give location) 6308 Livingston Road S. E.	
3. NAME OF DECEASED: (First) (Middle) (Last) DOROTHY WEESE EDELEN		4. DATE OF DEATH (Month) (Day) (Year) 8 15 19 55	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: August 6, 1930
9. AGE last birthday: 25 yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Waitress		10b. KIND OF BUSINESS OR INDUSTRY: Resturant	
11. BIRTHPLACE (State or foreign country): White Sulphur Springs, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry Weese		14. MOTHER'S MAIDEN NAME: Josephine Mullens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No:	
17. INFORMANT & ADDRESS: Harvey M. Weese 2809 Page Drive 22 Md.		Baltimore	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		13. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause Depressed skull fracture, left frontal and		DUE TO			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) sphenoid bones			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street		21c. (City or town) (County) (State) Fort Meade Anne Arundel Maryland	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 8/15/55 2:45 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Auto-auto collision	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>William J. [Signature]</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM <input type="checkbox"/>		DATE SIGNED 8/16/55	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal		DATE THEREOF Aug. 18, 1955		NAME OF CEMETERY OR CREMATORY Watco Cemetery	
LOCATION (City, town, or county) (State) White Sulphur Springs W. Va.		24. FUNERAL DIRECTOR Wm Cook - Blight, Inc.		ADDRESS 6009 Harford Road	
DATE REC'D BY LOCAL REG. 12-31		REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS
The law requires that the death certificate be executed within 24 hours after death.
The bottom copy may be retained by the hospital or attending physician.
The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7365

08242

CERTIFICATE OF DEATH

Item 9, Film 0186 9-19-55 et

Reg. Dist. No. 27

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
CITY OR TOWN Anne Arundel	COUNTY MARYLAND	STATE D.C.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Fort George G. Meade	LENGTH OF STAY (in this place) 15 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	16x-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital		STREET ADDRESS 6308 Livingston Rd. S.E.	✓
3. NAME OF DECEASED (Type or Print) WILMER R. EDELEN		4. DATE OF DEATH August 30 19 55	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH December 23, 1912 42 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Richard Edelen		14. MOTHER'S MAIDEN NAME Georgie Wilkinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT & ADDRESS Mrs. Joseph Duley, same as block #2.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) Contusion of Brain ANTECEDENT CAUSE(S) DUE TO (B) Multiple injuries due to auto accident DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 15 days	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Annapolis Md, Ft GG Meade A.A. Md.		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 2:30 PM Aug 10 55 M. 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 21f. HOW DID INJURY OCCUR? Head on collision	
22. I hereby certify that I attended the deceased from August 15 19 55, to August 31, 19 55, that I last saw the deceased alive on August 31, 19 55, and that death occurred at 2050 PM, from the causes and on the date stated above. SIGNATURE HERBERT L. NEEDLEMAN, 1ST LT MC ADDRESS Fort G.G. Meade, Maryland August 30, 1955 DATE			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR AUG 55	
25. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros, Upper Marlboro, Md.		26. ADDRESS Upper Marlboro, Md.	

SEP 6

08333

MARYLAND

7366

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH- COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY A.A.	
X CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bakersville		CITY (If outside corporate limits, write RURAL and give nearest town) OR Bakersville X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED (Type or Print) (First) Mallie (Middle) Virginia (Last) Gorman		4. DATE OF DEATH (Month) August (Day) 17 (Year) 1955	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH June 6, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE last birthday 55 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) Edenton Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas Smithson		14. MOTHER'S MAIDEN NAME Sarah Jane Beckett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mary C. Eaton, Baltimore 24, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Acute Coronary Occlusion			
Antecedent cause(s) (b) Decompenstation, Cardiac			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis, Advanced			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION None	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify) None	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY None	(CITY OR TOWN) None	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? None	

22. I hereby certify that I attended the deceased from 3/18, 1955, to 8/1, 1955, that I last saw the deceased alive on 8/17/55, and that death occurred at 5:15 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Aug 19 1955	NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	LOCATION (City, town, or county) Laurel, Maryland	(State)
DATE REC'D BY LOCAL REG. Aug 19-55	REGISTRAR'S SIGNATURE Clara Haslup	24. FUNERAL DIRECTOR Dr. W. H. Donaldson, Laurel, Md.		

COPIES RESERVED FOR BINDING

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1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7367

CERTIFICATE OF DEATH

07345

Reg. Dist. No.

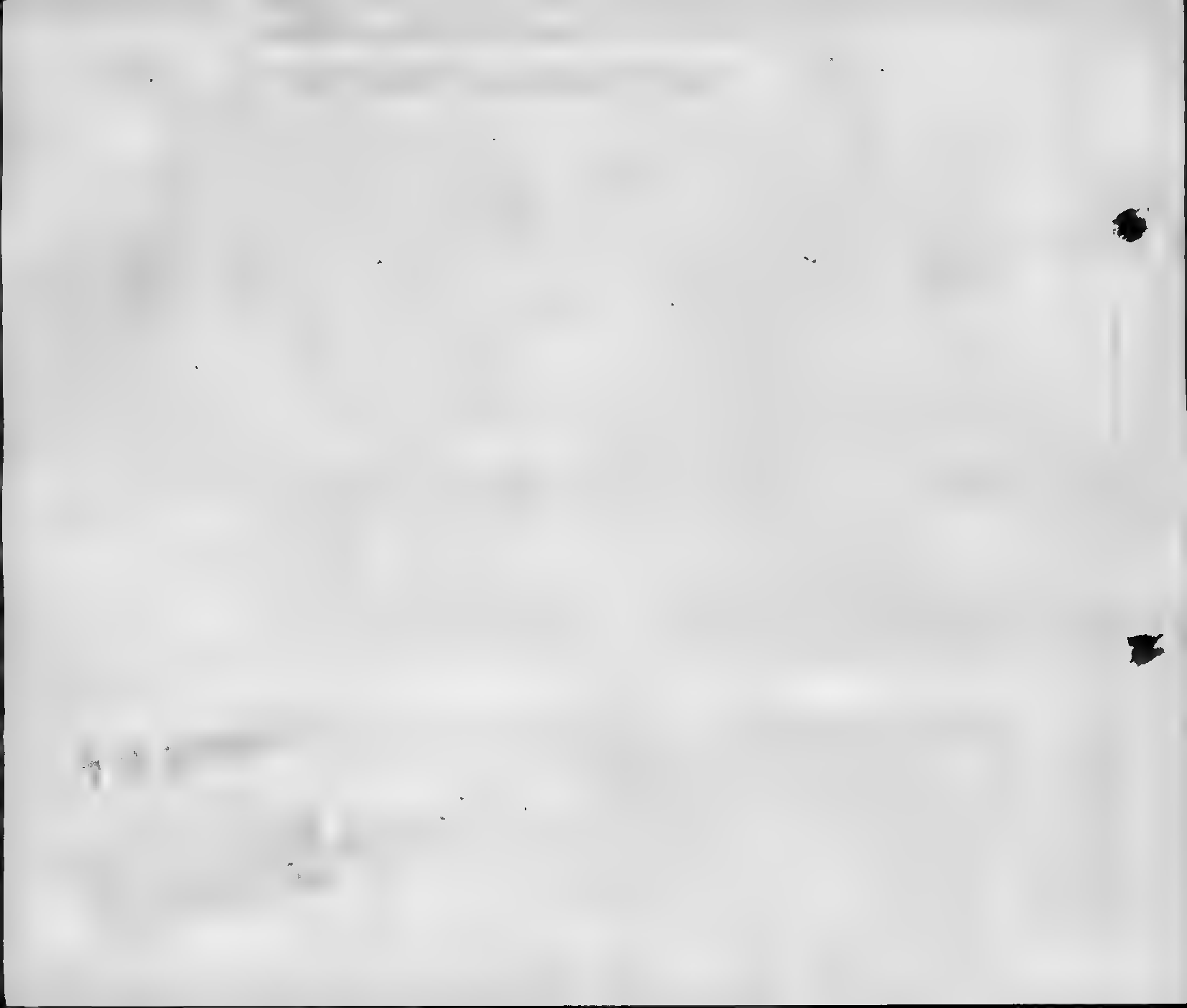
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Riva</u>		<u>1 year</u>		TOWN <u>Riva</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Shores</u>				STREET ADDRESS (If rural give location) <u>Sylvan Shores</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>George E. Gray</u>				<u>Aug 4th 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>mar.</u>	8. DATE OF BIRTH <u>Aug 7th 1889</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rep. Supervisor Merchandise</u>				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gray</u>				14. MOTHER'S MAIDEN NAME <u>Annie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-05-3648A</u>		17. INFORMANT & ADDRESS <u>Edna S. Gray, Riva, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>coronary heart disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary occlusion</u>						<u>7 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-4</u> , 19 <u>55</u> , to <u>8-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-4</u> , 19 <u>55</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edith Proller</u>		ADDRESS (Street, city, town, state) <u>M.D. 45 Franklin St. Annapolis, Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/8/55</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery Baltimore Co. Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Louis J. De Allegre</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cork, Inc.</u>		ADDRESS <u>1217 E. Paul St.</u>	
DATE <u>Aug. 9, 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

INSTRUCTIONS

ATTENDING PHYSICIAN - HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 2, 11, 13, 17, 14 filed 5-8-29-55 at

7368

CERTIFICATE OF DEATH

0734626

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>D. C.</u>		COUNTY <u>--</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Columbia Beach</u>				TOWN <u>Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>1708 2nd St., N.W.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Justin Greene</u>				<u>8th 20th 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS	
<u>F</u>	<u>C</u>		<u>Sept 21 - 1891</u>	<u>63</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Washington, D. C.</u>		<u>U.S.A</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Wilkes</u>				<u>Sadie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS			
				<u>Husband</u> <u>Residence: 1705 - 2nd St N.W.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Probable Coronary Occlusion</u>				<u>5 min.</u>			
ANTECEDENT CAUSE(S) DUE TO							
<u>History of hypertension</u>				<u>??</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
				<u>Heart attack during life</u>			
22. I hereby certify that I attended the deceased from <u>19</u> to <u>19</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>J. D. Hendricks</u>				<u>20 Aug 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Lincoln Memorial</u>		<u>Washington D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>8-21-55</u>		<u>George F. Hendricks</u>		<u>Robert M. Hendricks</u>		<u>1012 1st St. N.W.</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 515C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07347

7369 **CERTIFICATE OF DEATH**

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>W. Va.</u>		COUNTY <u>Kanawha</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ft Geo G. Meade</u>		<u>1 year</u>		TOWN <u>Charleston</u>		5X-	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ft Geo G Meade, Md. USAH</u>				STREET ADDRESS (If rural give location) <u>2831 Piedmont Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>William</u> (Middle) <u>Harlow</u> (Last) <u>Groah</u>				<u>Aug</u> <u>23</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Apr 27 1911</u>	<u>44</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Soldier</u>		<u>US ARMY</u>		<u>West Virginia</u>		<u>V. Va.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Harlow Groah</u>				<u>Ida Mae Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>15 yrs til present</u>		<u>unknown</u>		<u>Mrs. Bessie Groah</u> <u>1729 C, Forrest Ave, Ft Meade, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Acute myocardial infarction, posterior wall</u>						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
ANTECEDENT CAUSE(S) DUE TO <u>left ventricle, Thrombosis circumplex</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>coronary artery</u>							
18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DOA</u> , 19 <u> </u> , to <u>23 August 19 55</u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>MELBY N. BOBROW, 1/Lt MC Sobel</u>				<u>23 Aug 55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-24-55</u>		<u>Sunset Memorial Cemetery</u>		<u>Charlestown, W. Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 23 Aug 55</u>		<u>WM. E. SAYLOR, 1/Lt MSC</u>		<u>WM. COOK, INC., FALTO., MD.</u>			

LIBRARY A. 8

1955

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7370

CERTIFICATE OF DEATH

07348

Film C 186, 9-22-55 Items 13&14 bh

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>aa</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>AIT</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Fair Haven</i>		<i>20 yrs</i>		OR TOWN <i>Fair Haven</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
10				/			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Daniel</i> (Middle) <i>Gross</i> (Last)				(Month) <i>Aug</i> (Day) <i>27</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>		<i>15 May 1882</i>	<i>73</i> yrs.	<i>5</i> Months	<i>5</i> Days	<i>5</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Farmer</i>		<i>Agree</i>		<i>Anne Arundel Count.</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Samuel Thomas Gross</i>				<i>Martha Estep</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>217-09-1685A</i>		<i>Corrie A Smith, Fair Haven, MD</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <i>Coronary (aortic) failure</i>						<i>3 Months</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Atherosclerotic heart disease</i>						<i>Several years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <i>Pneumonia - 5 mos ago -</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March</i> , 19... to <i>April</i> , 19... that I last saw the deceased alive on <i>April</i> , 19... and that death occurred at <i>12:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>J. S. Hendricks</i>		M.D. <i>Shady Side Maryland</i>		ADDRESS (Street, city, town, state)		DATE SIGNED <i>8/27/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>Aug 29/55</i>		<i>Union Chapel</i>		<i>McKendree</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>8/26/55</i>		<i>Clarence Williams</i>		<i>Bernard Hardisty</i>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 104

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 515C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

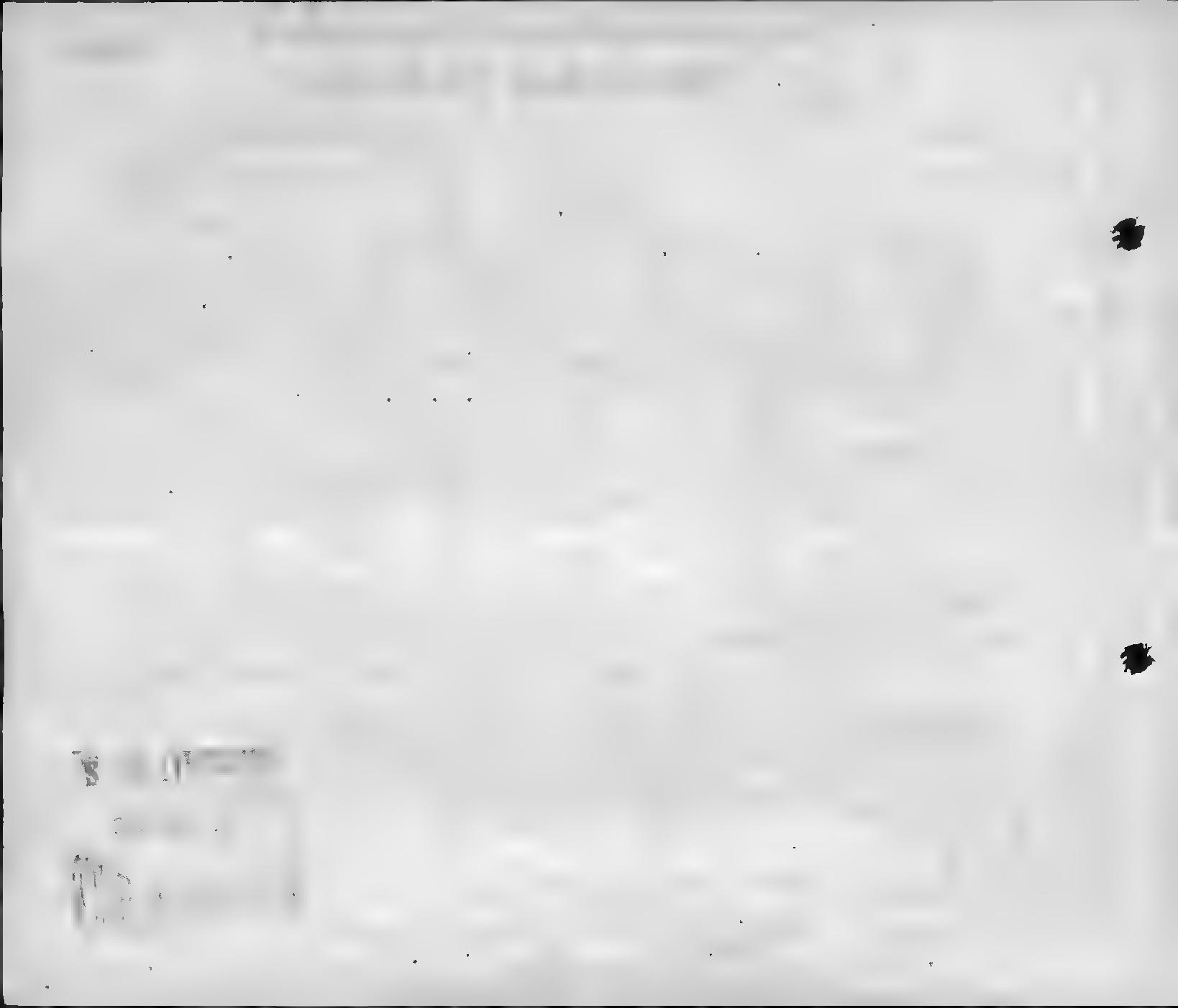
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7333

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		75 Yrs.		TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
30 Lafayette Ave.				30 Lafayette Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>CARRIE</u> (Middle) <u>ELIZABETH</u> (Last) <u>HARRIS</u>				August 19, 1955			
5 SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Colored	Widowed	June 27, 1877	78 yrs.	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		None		A. A. Co. Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Steven Johnson				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Edna Harris - Lafayette Ave. - Annapolis			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
(A) <u>Arteriosclerotic Hypertension</u>							
(B) <u>Cardiovascular disease grade III</u>						4 months	
(C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from May 4, 1955, to 8/19, 1955, that I last saw the deceased alive on 8/19, 1955, and that death occurred at 10:45 AM, from the causes and on the date stated above.							
SIGNATURE <u>R. B. Richardson</u>				ADDRESS (Street, city, town, state) DATE SIGNED <u>8/22/55</u>			
M.D. <u>110-Clay Street Annapolis, Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		8/22/55		Ashbury Cemetery		Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Aug. 22, 1955				Ethel L. Nick		45 Northwest St. Annapolis	



7334 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED					
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>				
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)					
TOWN <i>Annapolis</i>		TOWN <i>Annapolis</i>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Anne Arundel General</i>		STREET ADDRESS (If rural give location) <i>Bywater Road</i>					
3. NAME OF DECEASED (Type or Print) <i>Frederick C. Harris</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Aug. 16 1955</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 16, 1925</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Superintendent</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>70</i> yrs. <table border="1"><tr><td>IF UNDER 1 YEAR</td><td>IF UNDER 24 HRS.</td></tr><tr><td>Months</td><td>Days</td></tr></table>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days
IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Months	Days						
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Frederick C. Harris</i>		14. MOTHER'S MAIDEN NAME <i>Marie Wright</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>					
17. INFORMANT & ADDRESS <i>Mrs. F. C. Harris #2</i>							
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <i>Myo-cardial Infarction</i>		<i>5m.</i>					
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Hypertensive Cardio-Vascular Disease</i>		<i>2 yrs.</i>					
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)					
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <i>Jan. 1953</i> , to <i>Aug. 16, 1955</i> , that I last saw the deceased alive on <i>8-16-55</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>James R. Pratt</i>		DATE SIGNED <i>8/18/55</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		NAME OF CEMETERY OR CREMATORY <i>St. George's</i>					
DATE THEREOF <i>8-19-55</i>		LOCATION (City, town, or county) <i>Annapolis, Md.</i>					
24. REC'D BY REGISTRAR <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor & Son</i>					
DATE <i>Aug. 18, 1955</i>		ADDRESS					

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07351

7371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> OR TOWN <u>PASADENA</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3 Box 17</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>ANNE ARUNDEL</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u> OR TOWN <u>PASADENA</u> STREET ADDRESS (If rural give location) <u>ROUTE 3 BOX 17</u>													
3. NAME OF DECEASED (Type or Print) <u>MARGARET</u> (First) <u>HATTER</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>8</u> (Day) <u>25</u> (Year) <u>1955</u>													
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>APRIL 14 1972</u>		9. AGE last birthday <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>				11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>HENRY TWIST</u>						14. MOTHER'S MAIDEN NAME <u>MARY LOGUE</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT & ADDRESS <u>LANE LAWRENCE HATTER 1243 MAIDEN CHOICE</u>									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Constrictive heart failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>										18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u> </u>										19a. DATE OF OPERATION <u> </u>				19b. MAJOR FINDINGS OF OPERATION <u> </u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u> </u>				21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.) <u> </u>				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u> </u>									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) <u> </u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? <u> </u>									
22. I hereby certify that I attended the deceased from <u>1955</u> to <u>1955</u> , that I last saw the deceased alive on <u>Aug. 29, 1955</u> and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above. SIGNATURE <u>Joseph T. ...</u> DATE SIGNED <u>8/25/1955</u> <u>102 BALTO. AVE. ANNAPOLIS, MD.</u> ADDRESS (Street, city, town, state)																	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>AUG 27 55</u>				NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM</u>				LOCATION (City, town, or county) (State) <u>OLD FREDERICK RD MD.</u>					
24. REC'D BY REGISTRAR <u>Aug. 29, 1955</u>				REGISTRAR'S SIGNATURE <u>Louis J. ...</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Diffel Bros</u>				ADDRESS <u>1800 E LOMBARD ST</u>					

3 A 111111

501

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07352

7372

CERTIFICATE OF DEATH

Film G 186, 9-22-55 Item 12 & 8 bh

Reg. Dist. No. 26

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>AA</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Shady Side</u>	<u>6 yrs</u>	TOWN <u>Shady Side MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
(First) <u>Gustave</u> (Middle) <u>CHARL</u> (Last) <u>Heinrich</u>		August 30 1955	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>August 14, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>System Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>System</u>	11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Josephine Ernestine Graper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS <u>Philip Howard Shady Side MD</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4341 IMMEDIATE CAUSE (A) <u>Probable Coronary Occlusion</u>			<u>immediate</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST, DUE TO			<u>6 months</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb.</u> 19 <u>55</u> , to <u>Aug.</u> 30, 19 <u>55</u> , that I last saw the deceased alive on <u>Aug.</u> 23, 19 <u>55</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.			
SIGNATURE <u>W. Hendricks</u>		DATE SIGNED <u>31 Aug. 1955</u>	
ADDRESS (Street, city, town, state)			
M.D. Shady Side, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
<u>Burial</u>	<u>9/1/55</u>	<u>Good Hope Cemetery</u>	<u>Shady Side, Md.</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
<u>August 30</u>	<u>John B. Dant</u>	<u>Philip Howard</u>	<u>Shady Side, Md.</u>

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of names and addresses of the members of the committee.

SEP 6 1955

7373

CERTIFICATE OF DEATH

07353

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Middlebrook</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u> STREET ADDRESS (If rural give location) <u>142 King George St</u>	
3. NAME OF DECEASED (Type or Print) <u>Bertha V. Hyde</u>		4. DATE OF DEATH (Month) <u>AUG</u> (Day) <u>31</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>10/27/1900</u>
9. AGE last birthday <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Jacobs</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Drury</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u> </u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT & ADDRESS <u>Mrs. Caudell #2</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 16a. IMMEDIATE CAUSE (A) <u>Metastatic cancer of brain</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of lung</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>		ONSET AND DEATH <u>6 mos</u> <u>1 yr</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
21a. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Aug</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>55</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above.	
SIGNATURE <u>John H. Hyde</u>		ADDRESS (Street, city, town, state) <u>M.D. 40 Columbia St Annapolis, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>9/1/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
24. REC'D BY REGISTRAR <u>22-55</u>		REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Tyler & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10A

THE UNIVERSITY OF CHICAGO

CHICAGO, ILL.

SEP 1961

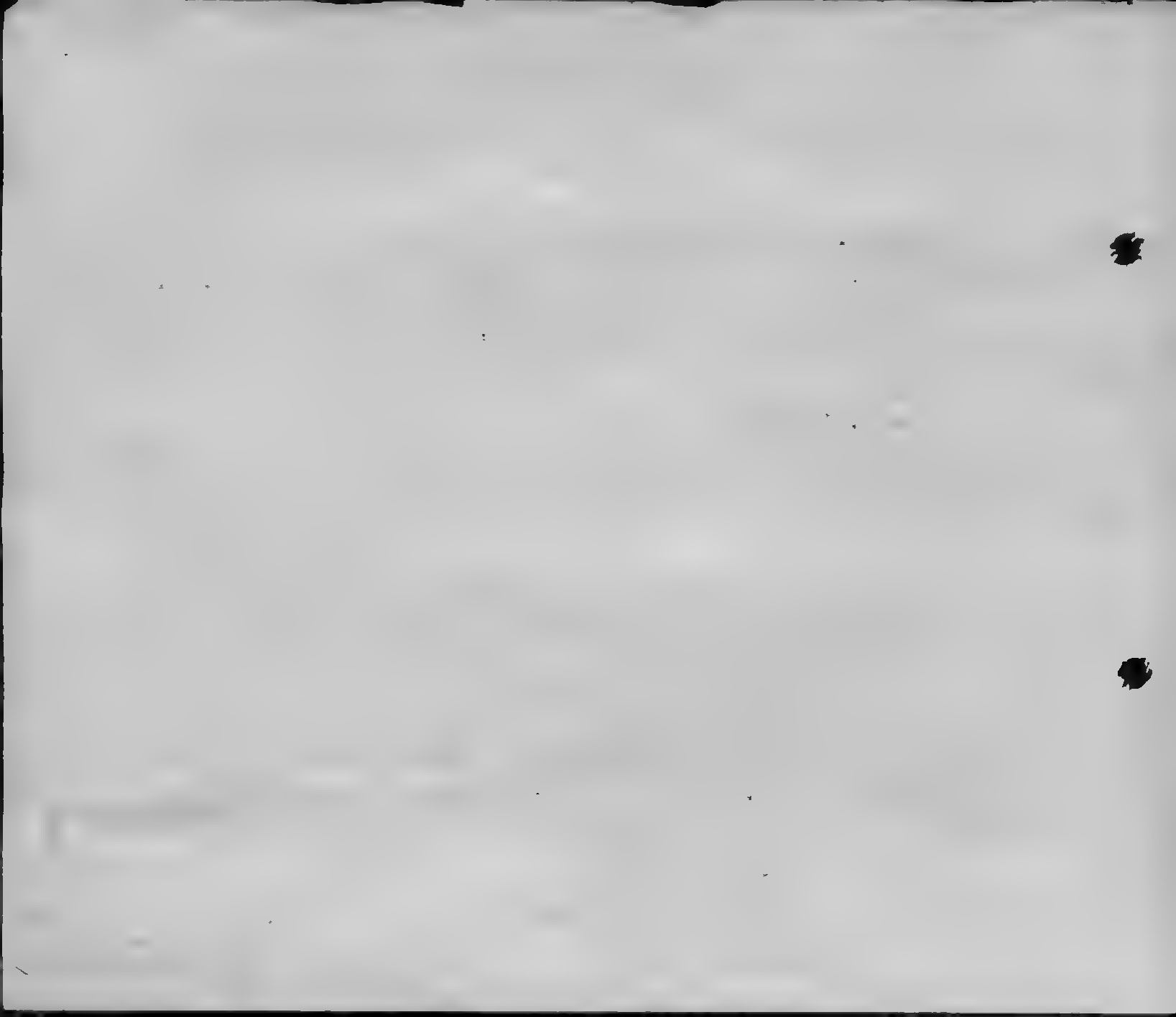
MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

0225
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 09342

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Jessup</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Md. House of Correction</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>MELVIN</u> <u>KENNETH</u> <u>JOHNSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug.</u> <u>15</u> <u>1955</u>		5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>July 11, 1925</u>		9. AGE last birthday: <u>30</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <u>Louis F. Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Rosa (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... <u>Stab wound of left side of mouth.</u> DUE TO Antecedent cause(s) (b) ... <u>Asphyxiation due to aspiration of blood</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>institution</u>		21c. (City or town) (County) (State) <u>Jessup</u> <u>Anne Arundel</u> <u>Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8/15/55 11:30 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Stabbed by another inmate at House</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. J. [Signature]</u>		M. D. <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> DATE SIGNED <u>8/16/55</u>			
23. BURIAL-CREMATION, REMOVAL (Specify): <u>Cremated</u>		DATE THEREOF <u>10/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>U. S. Md. Med. Sch. Bldg.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 10, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>The Anatomy Board of Maryland</u> ADDRESS <u>per: M. Christie</u>			



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07354

Item 21b Film 0186 9-8-55

7374

CERTIFICATE OF DEATH

Reg. Dist. No. 21

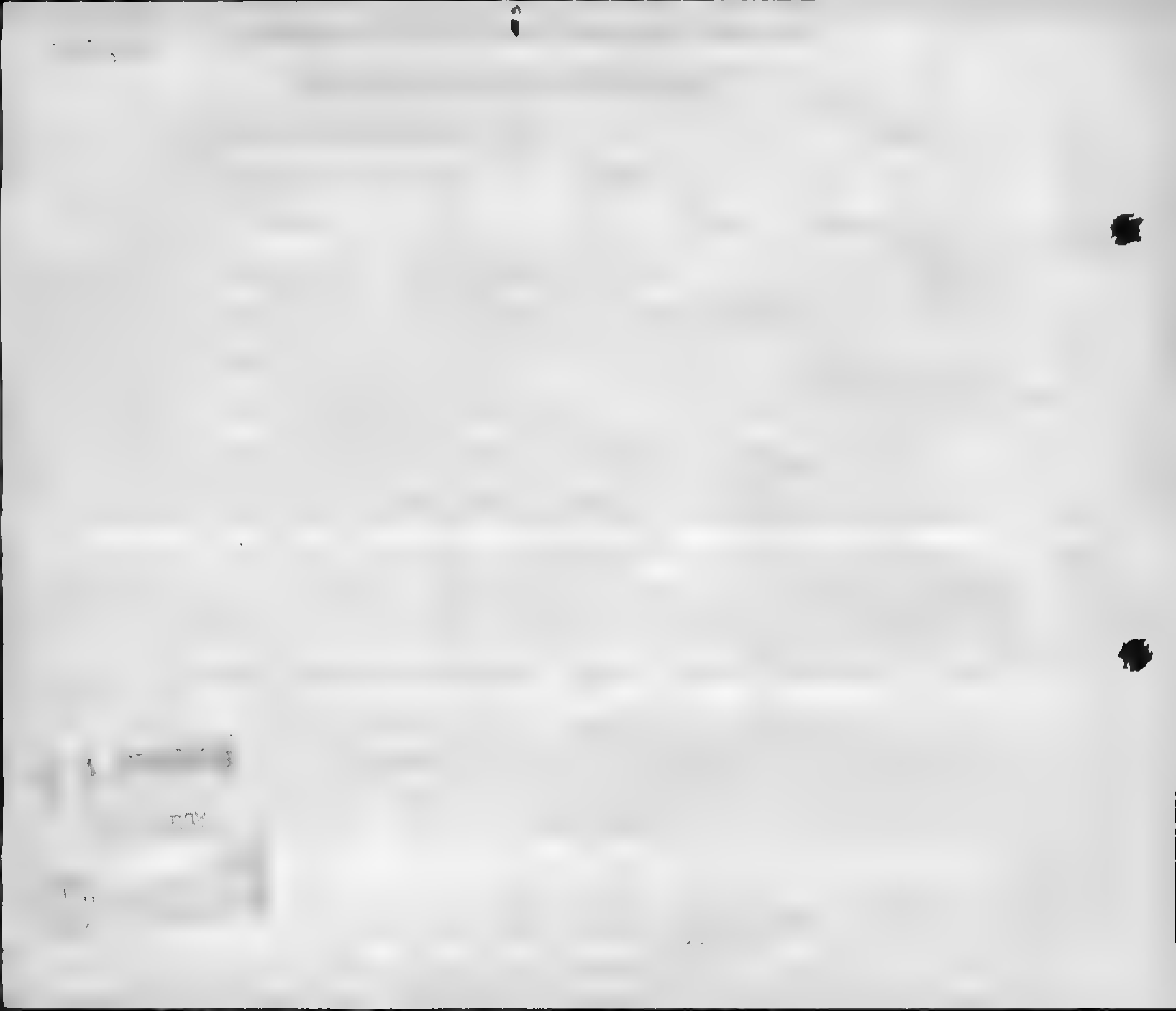
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A. A.</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>A. A.</i>	
CITY OR TOWN <i>Annapolisneck</i>		LENGTH OF STAY (in this place)		CITY OR TOWN <i>Annapolisneck</i>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (First, Middle, Last)				4. DATE OF DEATH (Month, Day, Year)			
<i>Sheilah Marie Johnson</i>				<i>Aug 15 1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>single</i>	8. DATE OF BIRTH <i>Apr 29 1955</i>	9. AGE last birthday <i>3</i> yrs.	10. UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Richard R. Johnson</i>				14. MOTHER'S MARRIAGE NAME <i>Lovel Parker</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Marie Johnson</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				921.0 IMMEDIATE CAUSE (A) <i>Asphyxia due to inspirator</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Emboli.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<i>Stroke</i>			
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>Home</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 15 1955</i> to <i>Aug 15 1955</i> , that I last saw the deceased alive on <i>Aug 15 1955</i> , and that death occurred at <i>6:00 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Sheilah Johnson</i>				DATE SIGNED <i>8/16/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug 18/55</i>		NAME OF CEMETERY OR CREMATORY <i>Trinity</i>		LOCATION (City, town, or county) <i>Annapolisneck Md</i>	
24. REC'D BY REGISTRAR <i>J. B. Johnson</i>		REGISTER SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	

VS 15C 1-55 10M

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS



INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07355

7335

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A. A. Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>A. A. Co.</u>			
CITY OR TOWN <u>10 Anna Polis</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Anna Polis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 4 Carver ST</u>				STREET ADDRESS <u>4 Carver ST</u>			
3. NAME OF DECEASED (Type or Print) <u>William Johnson</u>				4. DATE OF DEATH <u>8 1st 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>8-8-1891</u>	
9. AGE last birthday <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Eliza Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Ann. Md. Miss Jessie Johnson, 4 Carver ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7874 IMMEDIATE CAUSE (A) <u>Cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-0-1955</u> to <u>8-1-1955</u> , that I last saw the deceased alive on <u>7-26</u> , 19 <u>55</u> , and that death occurred at <u>1:35</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>W. J. French</u>				ADDRESS (Street, city, town, state) <u>M.D. 6 n Potomac rd St</u>		DATE SIGNED <u>8-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-3-55</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
24. REC'D BY REGISTRAR <u>Aug 30, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		ADDRESS <u>108 H. Wash St Annapolis, Md</u>	

Summary

52

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CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

Item 18 Film 7186 7-13-55 ams

7375

1. PLACE OF DEATH- COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>D.C.</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bristol</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>41X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Route 416</i>		STREET ADDRESS <i>1421 E. St. N.E.</i>	
3. NAME OF DECEASED (Type or Print) <i>Joan</i>		4. DATE OF DEATH (Month) <i>8</i> (Day) <i>28</i> (Year) <i>1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Single</i>	8. DATE OF BIRTH <i>July 27, 1935</i>
9. AGE last birthday <i>20</i> yrs		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>cleaner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Warehouse</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John J. Joy</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Powers</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY No. <i>-</i>	
17. INFORMANT AND ADDRESS <i>Mary D. Joy</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Collision & fire

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Auto-Auto collision

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) <i>Street</i>		(CITY OR TOWN) <i>Bristol</i>	(COUNTY) <i>A.P. Maryland</i>	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?				
OF INJURY <i>8-28-55 3:00 AM</i>	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<i>Collision & fire</i>				

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>8-30-55</i>	<i>St. Lincoln Cent</i>	<i>Baltimore</i>	<i>MD</i>
DATE REC'D BY LOCAL REG. <i>Aug. 28, 1955</i>	REGISTRAR'S SIGNATURE <i>Chas. W. Williams</i>	24. FUNERAL DIRECTOR <i>Francis Gasch + Sons, Hyattsville, Md.</i>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 1 1964
BUREAU OF THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

7376

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH Annapolis		2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND COUNTY ANNIE ARUNDEL	
CITY (If outside corporate limits, write RURAL and give nearest town) PASADENA		CITY (If outside corporate limits, write RURAL and give nearest town) PASADENA MD. (RURAL)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Boulevard Park		STREET ADDRESS Boulevard Park	
3. NAME OF DECEASED (Type or Print) CHARLES W. KAISER		4. DATE (Month) 8 (Day) 27 (Year) 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Sept 22, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL	9. AGE last birthday 61 yrs.
11. BIRTHPLACE (State or foreign country) HARFORD COUNTY MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES KAISER		14. MOTHER'S MAIDEN NAME MARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT & ADDRESS WILLIAM KAISER PASADENA MD.		18. MEDICAL CERTIFICATION Carcinomatosis general Carcinoma of rectum	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 154X IMMEDIATE CAUSE (A)		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DUE TO (C)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12:15 P. to 19 , that I last saw the deceased alive on 19 , and that death occurred at 12:15 P. M. from the causes and on the date stated above.			
SIGNATURE Joseph Taler		ADDRESS (Street, city, town, state) 102 Patton - Annapolis, Md.	
DATE SIGNED 8/27/1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF AUG 30 1955	
NAME OF CEMETERY OR CREMATORY GREEN HAVEN		LOCATION (City, town, or county) (State) GREEN BURNIE, MD.	
24. REC'D BY REGISTRAR L. J. DeAlba		REGISTRAR'S SIGNATURE L. J. DeAlba	
25. FUNERAL DIRECTOR'S SIGNATURE W. J. Singleton		ADDRESS Green Burnie, Md.	
DATE Aug 31, 1955			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled in by the funeral director, the third copy of this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit

VS AISC 1-55 10M

372

7336 CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annopolis</u> TOWN <u>Annopolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convalescent Home</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>3V01-4</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>705 N. Duncan Street</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH</u> First (Middle) (Last) <u>KNUDSEN</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>August 5, 1955</u>	
5. SEX. <u>female</u>	6. COLOR OR RACE. <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Feb. 20, 1877</u>
9. AGE last birthday <u>78</u> yrs		10. MONTH <u>8</u> Days <u>5</u> Hours <u>0</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
13. FATHER'S NAME: <u>Frederick A. Werner</u>		14. MOTHER'S MAIDEN NAME: <u>Dorothea W. Kraemer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Wilhelmina Pyles, 1509 E. Lafayette Ave</u>		18. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
19. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>592x</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic C. V. changes</u> ANTECEDENT CAUSE (B) <u>Chr. Nephritis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH <u>yes.</u> <u>yes.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/4</u> , 19 <u>55</u> , to <u>8/5</u> , 19 <u>55</u> that I last saw the deceased alive on <u>8/4</u> , 19 <u>55</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Maurice K. Lawans</u> M. D. ADDRESS <u>8/5/55</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>8/6/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>August 5 1955</u>		REGISTRAR'S SIGNATURE <u>R. D.</u>	
24. FUNERAL DIRECTOR <u>Wm. Gode Jr.</u>		ADDRESS <u>1217 St. Paul Street</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7377

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR TOWN) <u>LAUREL</u>	LENGTH OF STAY (in this place) <u>3 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LAUREL</u>	<u>Washington, D. C.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>District Training School</u>		STREET ADDRESS <u>804 Eye St., N.E.</u>	<u>47X 2</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Estelle</u> <u>-</u> <u>LAU</u>		OF DEATH <u>August 20</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Chinese</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>August 10 1950</u>
9. AGE last birthday <u>5</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>GUEY SEN LAU</u>		14. MOTHER'S MAIDEN NAME: <u>Shirley Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>District Training School's files</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>		<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Intestinal Toxemia</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Asthemia</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>(1) Microcephalic Idiot</u> <u>(2) Congenital cerebral spastic infantile paralysis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug. 18, 1955</u> , to <u>Aug. 20, 1955</u> , that I last saw the deceased alive on <u>August 20, 1955</u> and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Maureen Wages mola</u>		ADDRESS <u>M. D. District Training School</u>	
DATE SIGNED <u>August 20 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 22 55</u>	
NAME OF CEMETERY OR CREMATORY <u>West View School</u>		LOCATION (City, town, or county) <u>Laurel RFD Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug 20 - 55</u>		REGISTRAR'S SIGNATURE <u>Clara Horshup</u>	
		24. FUNERAL DIRECTOR <u>Walter Donaldson</u>	
		ADDRESS <u>Laurel Md</u>	

MARGIN RESERVED FOR BINDING



CERTIFICATE OF DEATH

Item 18 Film J186 9-13-55 amb

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bristol</u> TOWN <u>Bristol</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 416</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>D.C.</u> COUNTY <u>Washington</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> TOWN <u>Washington</u> STREET ADDRESS <u>219 - 115th St N.E.</u>	
3. NAME OF DECEASED (Type or Print) <u>Phyllis Ann Leech</u>		4. DATE OF DEATH (Month) <u>8</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 14 - 1940</u>
9. AGE last birthday <u>15</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis F. Leech</u>		14. MOTHER'S MAIDEN NAME <u>Mary Logan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Louis F. Leech - (2)</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

816X Immediate cause (a)

Collision & Fire

INTERVAL BETWEEN ONSET AND DEATH

Instantaneous

Antecedent cause (a)

Disease or condition, if any, giving rise to the above cause, stating the underlying cause last

(b) Auto-Auto collision

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Street

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 8-28-55 3:45 AMINJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

Collision & Fire

22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Aug 28, 1955Edw. West SullivanW.W. Chambers Co. Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

SEP 1 1971

RECEIVED

7379

CERTIFICATE OF DEATH

Items 13,14 Film 185 8-25-55 et

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY A.A.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Brooklyn

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 4103 Ritchie Hwy.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY A.A.CITY (If outside corporate limits, write RURAL and give nearest town) Brooklyn

STREET ADDRESS (If rural give location)

4103 Ritchie Hwy.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

DorraE.Lipp8161955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

FWMarriedOct. 2, 188471 yrs.

Months: Days: Hours: Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

housewifehousewifeBalto. Md.U.S.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

Frank SiebleDora Coasy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

John J. Lipp 4103 Ritchie Hwy.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a) Coronary occlusion

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertensive Cardio vascular

DUE TO

(c) disease

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 19, 1955, to July 19, 1955, that I last saw the deceased alive on July 3, 1955, and that death occurred at 4:00 pm, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

James G. Herbert M.D.4016 Ritchie Highway8/16/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8/16/55George J. GunceGeorge J. Gunce4001 Ritchie Hwy

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08344

7380

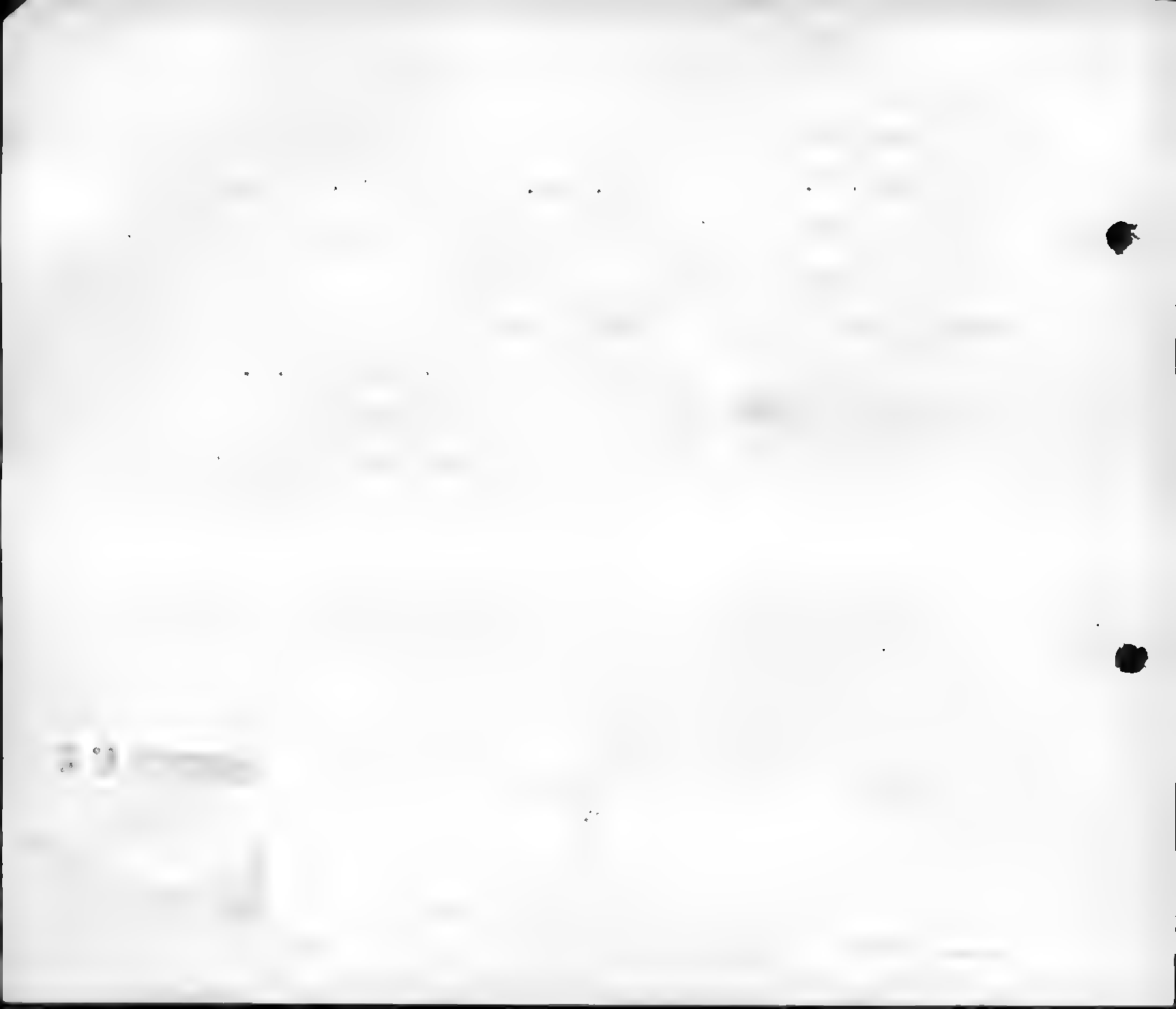
CERTIFICATE OF DEATH

Items 2, 3, Film 9-10-55 et

Reg. Dist. No.

22

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel, Md.</u>	LENGTH OF STAY (in this place) <u>12 yrs. 5 mos.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Laurel, Maryland</u>	<u>Washington, D.C.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>District Training School</u>		STREET ADDRESS <u>805 N St. N. W.</u>	(If rural give location) <u>District Training School</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Bertha</u>	(Middle) <u>Theresa</u>	(Last) <u>Lyles</u>	(Month) <u>August</u> (Day) <u>29</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>3/13/39</u>
9. AGE last birthday: <u>16</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
11. CITIZEN OF WHAT COUNTRY? <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>2</u>		14. MOTHER'S MAIDEN NAME: <u>Thelma Lyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>District Training School records</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
<u>3250</u> Immediate cause (a) <u>Otitis media Septic</u>		<u>2 weeks</u>	
Antecedent causes (s) (b) <u>Congenital cerebro spasm and ischiocy due to birth trauma</u>		<u>16 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Immunization</u>			
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Aug., 1955</u> , to <u>29 Aug., 1955</u> , that I last saw the deceased alive on <u>29 Aug., 1955</u> , and that death occurred at <u>9:35 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>Francis Maschuta</u>		DATE SIGNED <u>Aug 30-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>W. T. School Cemetery Laurel, Md Co</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Aug 30-55</u>		24. FUNERAL DIRECTOR <u>Dist Training School, Aug 30-55</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7381
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07361
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington</u> <u>47X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fort Meade Hospital</u>				STREET ADDRESS (If rural, give location) <u>300 G. St., N.W.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>VIRGINIA (DOLLY) FRANCES MARSH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 15</u> 19 <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Dec. 15, 1910</u>	
9. AGE last birthday: <u>44</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME: <u>Newell Walton</u>				14. MOTHER'S MAIDEN NAME: <u>Melinda Roston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No.: <u>---</u>		17. INFORMANT & ADDRESS: <u>Freddy Funeral Home, Charlottesville, Va.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<p><u>Crushing injury of chest</u></p> <p>Immediate cause (a)... DUE TO</p> <p>Antecedent cause(s) (b).....</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Street</u>		21c. (City or town) (County) (State) <u>Fort Meade Anne Arundel Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8/15/55 2:45 PM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Auto-auto collision</u>			
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>SIGNATURE <u>William W. [Signature]</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/16/55</u></p> <p>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>8/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>Charlottesville</u>		LOCATION (City, town, or county) (State) <u>Charlottesville, Va.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>New York, Inc., 1217 St. Paul Street</u>			



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 151C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7337

CERTIFICATE OF DEATH

07362

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		3 days		TOWN <u>Westport - Bello. 30</u>		x	
HOSPITAL OR INSTITUTE OR ON STREET ADDRESS				STREET ADDRESS (If rural give location)			
12 <u>Anne Arundel Gen'l. Hosp.</u>				2212 <u>Annapolis Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Thomas</u> (Middle) <u>Patrick</u> (Last) <u>McKewen</u>				(Month) <u>Aug.</u> (Day) <u>1-7</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Nov. 19, 1898</u>	<u>66</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Plant Engineer</u>		<u>Koppers Co.</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John McKewen</u>				<u>Elizabeth Nally</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>241-05-3107</u>		<u>Thomas D. McKewen</u> <u>Box 495</u> <u>Shore Acres</u> <u>Pasadena, Md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
44- <u>X</u> IMMEDIATE CAUSE (A)				<u>1 Cerebral Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				<u>2 Nerves in Arteries</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>3 Hypertension & V disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Dec. 1954</u> to <u>Aug. 1955</u> , that I last saw the deceased alive on <u>Aug. 1955</u> , and that death occurred at <u>Aug. 1955</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Wm. J. French</u>				<u>Aug 17, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Aug. 30, 1955</u>		<u>Glen Haven</u>		<u>Glen Burnie</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug 31, 1955</u>		<u>Wm. J. French</u>		<u>R. V. Ling. Jr.</u>		<u>Glen Burnie, Md.</u>	

SEP 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7333
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07363

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel	MARYLAND	STATE Maryland	COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL OR and give nearest town) 10 TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 Annapolis-City Dock		STREET ADDRESS (If rural, give location) 1	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) CHARLES NEWSOME		4. DATE OF DEATH (Month) (Day) (Year) Aug. 23 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH: Nov. 17, 1900
9. AGE last birthday: 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): House Painter	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: James Newsome		14. MOTHER'S MAIDEN NAME: Bessie Louise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Mrs. Bessie Carpenter Laurel Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Drowning DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: City Dock-Annapolis-Anne Arundel, Md.	
21c. (City or town, (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Found 8/23 3:30 M	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Body found by youngster while crabbing	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
SIGNATURE: [Signature]		M. D. DATE SIGNED: 8/24/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF: Aug 25 1955	
NAME OF CEMETERY OR CREMATORY: Laurel Hill		LOCATION (City, town, or county) (State): Laurel P. D. Md.	
DATE REC'D BY LOCAL REG: Aug 25 1955		24. FUNERAL DIRECTOR: [Signature] ADDRESS: Laurel Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07364

7382

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md.</u> COUNTY <u>3 Vol-4</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		OR TOWN <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GREEN BURNIE</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)		ADDRESS <u>1923 DIVISION ST.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>VIOLET NIXON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8 2 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOWED</u>		8. DATE OF BIRTH <u>MAR. 29, 1898</u>	
9. AGE last birthday <u>57</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>HOUSEWIFE</u>)		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LAWRENCE CLEMENTS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT'S ADDRESS <u>Mrs. CLEMENTS NIXON</u>				<u>2200 BRADDOCK AVE.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4220 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis general.</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 30, 1955</u> to <u>Aug 2, 1955</u> , that I last saw the deceased alive on <u>July 30, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph TALER</u>		ADDRESS (Street, city, town, state) <u>102 BALTO-ANNAP. BLVD. GLENBURNIE, MD.</u>		DATE SIGNED <u>8/3/1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug. 6 '55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Louis J. DeAlto</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. ...</u>		ADDRESS <u>1651 ...</u>	
DATE <u>Aug 5, 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07365

7339

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (If this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>Annapolis, Md.</u>		27 days		TOWN <u>Glen Isle, Riva, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
163 <u>Anne Arundel Gen. Hosp. Franklin St.</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Melissa Carrie O'Callaghan</u>				<u>August 15, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	White	Married	Feb. 28, 1892	63 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Washington, D.C.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Williamson</u>				<u>Katie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No				<u>Mr. Edwin A. O'Callaghan</u> <u>Riva, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>Intestinal obstruction</u>						<u>1 month</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Papillary adenocarcinoma- primary site</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>undetermined.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>July 23, 1955</u>		<u>Intestinal obstruction</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 11, 1955</u> to <u>Aug. 15, 1955</u> , that I last saw the deceased alive on <u>Aug. 11, 1955</u> , and that death occurred at <u>3:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Jane L. Wilkins</u>		<u>98 Cathedral St. Annapolis, Md.</u>		<u>Aug/ 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>8-17-1955</u>		<u>Wash. D.C.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Aug. 16, 1955</u>		<u>Am. J. Funches</u>		<u>Robert A. Mattingly</u>		<u>131-11 Ave W. Wash. DC</u>	

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. L.

1968

James E. Sullivan

2-15-1982

Account of Sullivan
for the year 1981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7382

07366

Reg. Dist. No. 28

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>25 years</u>		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 301</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Lucia</u>		(Middle) <u>Mary</u>		(Last) <u>O'Keefe</u>		(Month) (Day) (Year)	
(Type or Print)						<u>Aug. 29 1955</u>	
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>Aug. 20-1872</u>	
						9. AGE last birthday: <u>83</u> yrs.	
						IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Own Home</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ireland, County Wick</u>	
13. FATHER'S NAME: <u>James J. Hallahan</u>				14. MOTHER'S MAIDEN NAME: <u>Magaret C. Shea</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war of dates of service) <u>No</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Miss Timothy A. C. Keefe (sister)</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u> </u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u> </u>						<u>2 weeks</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE							
<u>James J. Keefe</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/29/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>9-1-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Our Lady of the Field</u>		LOCATION (City, town, or county) (State) <u>Malloryville, Maryland</u>	
DATE REC'D BY LOCAL REG <u>Sept 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Therese M. Joyce</u>		FUNERAL DIRECTOR <u>R. J. Singleton - Glen Burnie</u>		ADDRESS <u> </u>	
		<u>L. J. DeAlba</u>					

U. S. A.

7 178

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7340

CERTIFICATE OF DEATH

07367

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <i>Annapolis</i>				OR TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>USN Experimental Stn.</i>				STREET ADDRESS (If rural give location) <i>USN Experimental Station</i>			
3. NAME OF DECEASED (Type or Print) <i>DEAR W. OLSON</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Aug 13 1953</i>			
5 SEX <i>Male</i>	6 COLOR OR HAIR <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widower</i>	8. DATE OF BIRTH <i>10-2-1883</i>	9. AGE last birthday <i>71</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boiler Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Sweden</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Andrew P. Olson</i>				14. MOTHER'S MAIDEN NAME <i>Mt. Knew</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS <i>Daniel C. Olson #2</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
16a. IMMEDIATE CAUSE (A) <i>Carcinoma lung (bronchogenic)</i>				6-8 mos			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Carcinoma of lung</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6/29/55</i> , 19 <i>55</i> , to <i>8/13</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>8/12</i> , 19 <i>55</i> , and that death occurred at <i>11:30</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>S. Borromy</i> M.D.				ADDRESS (Street, city, town, state) <i>Amos Gunter Street, Annapolis, Md 21403</i>		DATE SIGNED <i>8/13/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>8/20/55</i>		NAME OF CEMETERY OR CREMATORY <i>Fairfield Memorial</i>		LOCATION (City, town, or county) (State) <i>Stamford Conn.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>		ADDRESS <i>John H. Taylor & Sons, Annapolis, Md.</i>	
DATE <i>Aug 19, 1955</i>							

JOHN A. BROWN
AUG 10 1961

100-100000-100000

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7384

07365

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Pasadena, Md.</u>				TOWN <u>Balto.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>				STREET ADDRESS (If rural, give location) <u>135 S. 2nd St.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>HERMAN</u>		(Middle)		(Last) <u>PATTERSON</u>	
				4. DATE OF DEATH		(Month) (Day) (Year)	
				<u>August 22</u>		<u>19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>none</u>		8. DATE OF BIRTH: <u>6-18-1945</u>	
						9. AGE last birthday: <u>10</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Patterson</u>				14. MOTHER'S MAIDEN NAME: <u>Ethel McLean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Ethel Patterson same</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Drowning</u>							
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>water</u>		21c. (City or town) (County) (State)			
<u>Found: Pasadena Anne Arundel Md.</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY found <u>8/22/55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Found drowned</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. F. [unclear]</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>8/23/55</u>	
		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, OR REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>8-25-55</u>		NAME OF CEMETERY OR CREMATORY <u>My Cemetery</u>		LOCATION (City, town or county) (State) <u>Brooklyn Md.</u>	
DATE REC'D BY LOCAL REG. <u>8/23/55</u>		REGISTRAR'S SIGNATURE <u>[unclear]</u>		24. FUNERAL DIRECTOR <u>W. S. Wilson</u>		ADDRESS <u>2004 Orleans St.</u>	



7341
CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: <i>Long Island</i>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>ANNAPOLIS</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Edgewater Md.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>ANNAPOLIS</i>		LENGTH OF STAY (in this place) <i>1 Month</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Selby on the Bay</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Homewood Convalescent Home</i>				STREET ADDRESS (If rural, give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>ALMA</i> (Middle) (Last) <i>PAUSEN</i>				4. DATE OF DEATH: (Month) <i>8</i> (Day) <i>22</i> (Year) <i>1955</i>			
5. SEX: <i>FEMALE</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>MARRIED</i>	8. DATE OF BIRTH: <i>MAR 21 1884</i>		9. AGE last birthday: <i>71</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Pa</i>	
13. FATHER'S NAME: <i>Samuel E. Jones</i>				14. MOTHER'S MAIDEN NAME: <i>Phelma J. Brown Hathi Fink</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Phelma J. Brown 1376 Bryant St NE Washington D.C.</i>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.0		(a) <i>Arteriosclerotic Heart Disease</i>		<i>unknown</i>	
Immediate cause		DUE TO			
Antecedent cause(s)		(b) <i>Generalized Arteriosclerosis</i>		<i>unknown</i>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO			
		(c)			
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:	
				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE HOMICIDE		OF INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <i>8/19</i> , 19 <i>55</i> , to <i>8/22</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>8/21</i> , 19 <i>55</i> , and that death occurred at <i>6:20 A.M.</i> , from the causes and on the date stated above.					
SIGNATURE <i>Eduard J. Beeb</i>		(DEGREE OR TITLE) <i>MD</i>		ADDRESS <i>41 Southgate Ave Annapolis</i>	
DATE SIGNED <i>8/22/55</i>					
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>8-25-55</i>		NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill</i>	
LOCATION (City, town, or county) <i>Annapolis, Md.</i>					
DATE REC'D BY LOCAL REG. <i>Aug. 22, 1955</i>		FURNER'S SIGNATURE <i>T.W. Knott</i>		24. FUNERAL DIRECTOR ADDRESS <i>W.W. Chambers Co. 5801 Cleveland Ave. Riverdale, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V. 8

1886

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07370

7342

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Riva.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location)		/	
3. NAME OF DECEASED (First) (Middle) (Last) <u>VICTORIA PHILLIPS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 20, 1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Divorced</u>	8. DATE OF BIRTH <u>10-8-1871</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cor. brat Vascular accident</u>						<u>48 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1952, to..... 8/20, 1955, that I last saw the deceased alive on..... 8/20, 1955, and that death occurred at 6:35 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city, town, state) <u>M.D. Annapolis Md</u>		DATE SIGNED <u>8/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 29 55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>	
24. REC'D BY REGISTRAR <u>8-29-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>ANNAPOLIS, MD.</u>			

13 1/2

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7385

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>P.A.Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Pasadena P.D.</u>		<u>14 months</u>		OR TOWN <u>Pasadena P.D.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Belhaven Ave. Belhaven Beach</u>				<u>Belhaven Ave. - Belhaven Beach</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
<u>Ester</u>		<u>Mary</u>		<u>August 8</u>		<u>19 1955</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Married</u>		<u>Feb. 14-1883</u>	
9. AGE last birthday: IF UNDER 1 YEAR		Months		Days		Hours	
<u>72 yrs.</u>							
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country).	
<u>Knockwork (Rel.)</u>				<u>own home</u>		<u>Deerier, Georgia</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William James Wallace</u>				<u>Mary Stuart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>				<u>None</u>		<u>Herman W. Platka</u>	
						<u>Belhaven Beach</u>	
						<u>Pasadena, Md.</u>	

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<u>420.1</u>					
Immediate cause (a)				<u>Coronary Thrombosis</u>	
Antecedent causes (s) (b)				<u>Hypertension</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.					
(c)					
11. OTHER SIGNIFICANT CONDITIONS				12. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death.				<u>Not Known</u>	
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION	
				<u>Chronic Cholecystitis</u>	

21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour)				INJURY OCCURRED		HOW DID INJURY OCCUR?					
OF INJURY				While at Work		Not While At Work					

22. I hereby certify that I attended the deceased from <u>May 31</u> , 19 <u>55</u> , to <u>Aug. 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 8</u> , 19 <u>55</u> , and that death occurred at <u>2:45 P.M.</u> , from the causes and on the date stated above.											
SIGNATURE				ADDRESS				DATE SIGNED			
<u>R.M. McLaughlin</u>				<u>Pasadena, Md.</u>				<u>Aug. 8, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>				<u>Aug. 11, 1955</u>		<u>Glen Haven Cemetery</u>		<u>Glen Burnie, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR				REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR			
<u>Aug 10, 1955</u>				<u>L.J. DeAlba</u>				<u>R.V. Singleton - Glen Burnie, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 11 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07372

7386 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Hanover</u>		<u>6 yrs</u>		TOWN <u>Hanover</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Race Road</u>				STREET ADDRESS (If rural give location) <u>Race Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Edward George Pumphrey</u>				<u>August 20, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. UNDER 1 YEAR (Months) (Days) (Hours) (Min.)		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 18, 1923</u>	<u>32</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Machinist</u>		<u>Macey's Machine Shop</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward L. Pumphrey</u>				<u>Margaret B. Krause</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>21516 9989 Md.</u>		<u>Ed. L. Pumphrey</u> <u>Eighth Ave. N. W.</u> <u>Glen Burnie</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
411X IMMEDIATE CAUSE (A)				<u>Coronary Infarction</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Aortic Insufficiency (Severe)</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO				<u>Rheumatic Heart Disease</u>			
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>11/15/54</u>		<u>Aortic Insufficiency</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u>, 19<u>54</u>, to <u>Aug</u>, 19<u>55</u> that I last saw the deceased alive on <u>July 20, 1955</u>, and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE HEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>John M. Allen</u>		<u>Aug 23/55</u>		<u>Glen Haven</u>		<u>Glen Burnie, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>John M. Allen</u>		<u>John M. Allen</u>		<u>Glen Burnie, Md.</u>	
DATE		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>August 25 1955</u>		<u>John M. Allen</u>		<u>John M. Allen</u>		<u>Glen Burnie, Md.</u>	

BUREAU W. C.

NOV 23 1955

J. Edgar Hoover
Director

7387 **CERTIFICATE OF DEATH**

07373

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (In this place) <u>8 yrs. 29 das.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Indian Head</u>		<u>08x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>↓</u>			
3. NAME OF DECEASED (Type or Print) <u>Della</u> (First) <u>Queen</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>1</u> (Year) <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE last birthday <u>25</u> yrs.	IF UNDER 1 YEAR Months <u>25</u> Days <u>25</u> Hours <u>25</u> Min. <u>25</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						Known to us since 7/3/47	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Epileptiform Seizures</u>						Known to us since 7/3/47	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Juvenile Paresis</u>						Known to us since 7/3/47	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIT ON CAUSING DEATH. <u>Pulmonary Tuberculosis</u>						Known to us since 7/3/47	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/6/55</u> 19....., to <u>8/1</u> 19.....55., that I last saw the deceased alive on <u>8/1/55</u> 19.....55....., and the death occurred at <u>8:30 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edyard Head Reimer</u>				ADDRESS (Street, city, town, state) <u>Crownsville State Hospital</u>		DATE SIGNED <u>8/1/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>8/4/55</u>	NAME OF CEMETERY OR CREMATORY <u>Hilltop</u>		LOCATION (City, town, or county) <u>Hilltop</u>		(State) <u>M.D.</u>	
24. REC'D BY REGISTRAR <u>P. J. Joyce</u>	REGISTRAR'S SIGNATURE <u>P. J. Joyce</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Perry & Co. Inc.</u>		ADDRESS <u>Brown Springs Rd.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

Handwritten signature or text, possibly "Handwritten" or "Handwritten".

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7388

CERTIFICATE OF DEATH

07375

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>		<u>8 years</u>		TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>401 Third Ave., S.W.</u>				STREET ADDRESS (If rural give location) <u>403 Third Ave., S.W.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u>		(Middle) <u>E.</u>		(Last) <u>Reynolds</u>		(Month) <u>August</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 30, 1872</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Woodsborough, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Harris</u>				14. MOTHER'S MAIDEN NAME <u>Julia A. Stout</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Lloyd C. Reynolds 401 Third Ave. Glen Burnie Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug. 22, 1955, to Aug. 14, 1955, that I last saw the deceased alive on Aug. 8, 1955, and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Bobby L. Jancy, M.D.</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Burnie Cem.</u>		LOCATION (City, town, or county) <u>Ba. Md.</u>	
24. REC'D BY REGISTRAR <u>L. J. Dealba</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hightower</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>Aug. 18, 1955</u>							

RECEIVED
AUG 22 1955
U.S. AIR FORCE

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7389

CERTIFICATE OF DEATH

07376

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie</u>				TOWN <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#711 Washington Ave.</u>				STREET ADDRESS (If rural give location) <u>#711 Washington Ave. Glen GARDENS</u>			
3. NAME OF DECEASED (Type or Print) <u>Irvin H. Riegel</u>				4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>24 May 1897</u>	
9. AGE last birthday <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher (ret)</u>		11. BIRTHPLACE (State or foreign country) <u>Eden Valley, Minnesota U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin F. Riegel</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Kickbush</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT & ADDRESS <u>Bess B. Riegel #711 Washington Ave. Glen Burnie, Md</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
452.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>CORONARY ARTERIO SCLEROSIS</u>						<u>9 YRS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>BRONCHIECTASIS</u>						<u>10 YRS.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH						19. DATE OF OPERATION	
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?		21g. DATE OF OPERATION	
22. I hereby certify that I attended the deceased from <u>Nov. 54</u>, to <u>Aug. 3, 1955</u>, that I last saw the deceased alive on <u>Aug. 3, 1955</u>, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leon C. Perry</u>				DATE SIGNED <u>8-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR			
DATE THEREOF <u>5 August 55</u>				NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. DeAlba</u>				26. ADDRESS <u>2013 E. A. Blvd. Glen Burnie, Md.</u>			
27. DATE <u>Aug 5, 1955</u>				28. ADDRESS <u>Baltimore, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 48 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



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7390 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Burnie P.O.</u>		<u>3 yrs</u>		TOWN <u>Glen Burnie P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#2 Wells Ave., Fenndale</u>				STREET ADDRESS (If rural give location) <u>#2 Wells Ave., Fenndale</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Gustav Adolf Schmale</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 31, 1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 9, 1885</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinists Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. P.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Schmale</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ida ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>705 07 9237</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary O. Schmale</u>		<u>2 Wells Ave. Fenn Dale Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CORONARY ARTERIOSCLEROSIS</u>				<u>44 YRS.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 5, 1953</u> to <u>Aug 31, 1955</u> , that I last saw the deceased alive on <u>8-26, 1955</u> , and that death occurred at <u>5:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leon C. Perry</u>				DATE SIGNED <u>8-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 3/55</u>		NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Park</u>		LOCATION (City, town, or county) <u>Washington Blvd. Md.</u>	
24. REC'D BY REGISTRAR <u>L. J. DeAlba</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. K. Kingston</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>Sept 7 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7391

-07378

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>HARWOOD</u>		LENGTH OF STAY (in this place) <u>40 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>HARWOOD</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Thomas Reiner</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married Oct 8 1914</u>		8. DATE OF BIRTH: <u>40</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country): <u>Harwood, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas M. Sears</u>				14. MOTHER'S MAIDEN NAME: <u>May Phipps</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>—</u>		17. INFORMANT & ADDRESS: <u>Thomas Sears, Harwood Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
976X Immediate cause		(a) <u>Gun shot wound chest</u>		DUE TO			
Antecedent cause(s)		(b) <u>—</u>		DUE TO			
Diseases or conditions, if any, giving rise to the above cause		(c) <u>—</u>		stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>)		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8 11 55 A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Self inflicted gun shot</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John F. [Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8/13/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>8/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Harwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Harwood Md</u>	
DATE REC'D BY LOCAL REG <u>8/13/55</u>		REGISTRAR'S SIGNATURE <u>Benjamin Williams</u>		24. FUNERAL DIRECTOR <u>Benjamin Williams</u>		ADDRESS <u>Harwood</u>	

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7343

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) (in this place)
 10 TOWN Annapolis 3 yrs.
 90 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS Homeswood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY aa
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR Severna Park
 TOWN Severna Park
 STREET ADDRESS (If rural, give location)
McKinsey Rd.

3. NAME OF DECEASED:

(First) (Middle) (Last)
Mabel Rowland Shepard
 (Type or Print)

4. DATE OF DEATH: (Month) (Day) (Year)
Aug. 31, 1955

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

W

8. DATE OF BIRTH:

January 3, 1870

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

85 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

none

10b. KIND OF BUSINESS OR INDUSTRY:

—

11. BIRTHPLACE (State or foreign country):

Pittsburg Pa

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

A Judson Rowland D.D.

14. MOTHER'S MAIDEN NAME:

Harriet Frick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Mrs Alfred M Geis Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause

(a)

DUE TO

Senile degeneration

Antecedent cause(s)

(b)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

Arteriosclerotic Cardio Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
 INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
 OF INJURY

INJURY OCCURRED
 While at Not while
 M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1952 to 8/31, 1953, that I last saw the deceased

alive on 8/31, 1953, and that death occurred at 11:20 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

Margaret K. Williams M.D.Annapolis, Md9/2/53

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTERAR'S SIGNATURE

FEDERAL DIRECTOR

ADDRESS

Sept. 7, 1955Dr. J. FrenchW. JenkinsAns Co 4905 York Rd

MARGIN RESERVED FOR BINNING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7341

CERTIFICATE OF DEATH

07380

Reg. Dist. No. 21

Item 12, Film G187 9-28-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>10</u>				TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>65 Southgate Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby Girl</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 9 19 55</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>9 August 1955</u>		9. AGE last birthday <u>yr.</u>	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>				IF UNDER 1 YEAR Months Days <u>2 32</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Wilson SIEVER</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Mae GOTT</u> <u>Kathleen Studd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S ADDRESS <u>Hospital Records & Family</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Immaturity with prematurity</u>						<u>2 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 Aug.</u> , 19 <u>55</u> , to <u>9 Aug.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9 Aug.</u> , 19 <u>55</u> , and that death occurred at <u>3:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James C. Hopper</u>				U. S. Naval Hospital M.D. <u>Annapolis, Maryland</u> <u>9 Aug. 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 11, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Naval Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR <u>August 11, 55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME Annapolis, Md.</u>			

U.S. DEPARTMENT OF THE INTERIOR

AUG 12 1904

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7345

CERTIFICATE OF DEATH

07381

Reg. Dist. No...

Item 8, Film G185 8-17-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>A.A. Co.</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ANNA POLIS</u>		TOWN <u>ANNA POLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>54 SHAW ST</u>		<u>54 Shaw Street</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		DEATH <u>8</u> <u>7</u> 19 <u>55</u>	
<u>John Henry SIMMS</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Male</u>	<u>Colored</u>	<u>W</u>	<u>4-16-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday
<u>Retired</u>			<u>61</u> yrs.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>John H. SIMMS</u>		<u>JULIA A. ENNIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS			
<u>ANNA. Md</u> <u>CORSINA ALTON, 54 SHAW ST</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
4-1-1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular</u>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Disease</u>		<u>3 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While of work Not while of work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>August 6, 1955</u> to <u>August 7, 1955</u> , that I last saw the deceased alive on <u>August 7, 1955</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>W. H. Richardson</u>		<u>8/8/55</u>	
M.D. <u>110-6149 St Ann's, Md</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>ANNA POLIS NATIONAL ANNA POLIS</u>	
DATE THEREOF		LOCATION (City, town, or county)	
<u>8-10-55</u>		<u>ANNA POLIS, Md</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>Wm. J. French</u>		<u>William Reese, #105 W. Wash. St</u>	
DATE <u>Aug. 9, 1955</u>		<u>ANNA POLIS, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

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1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

2. The second part of the document is a series of handwritten notes or entries. These are written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates in the first part, possibly providing additional information or commentary.

3. The third part of the document is a series of handwritten notes or entries, similar to the second part. These are also written in a cursive script and are organized into a list format. The notes appear to be related to the names and dates in the first part, possibly providing additional information or commentary.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

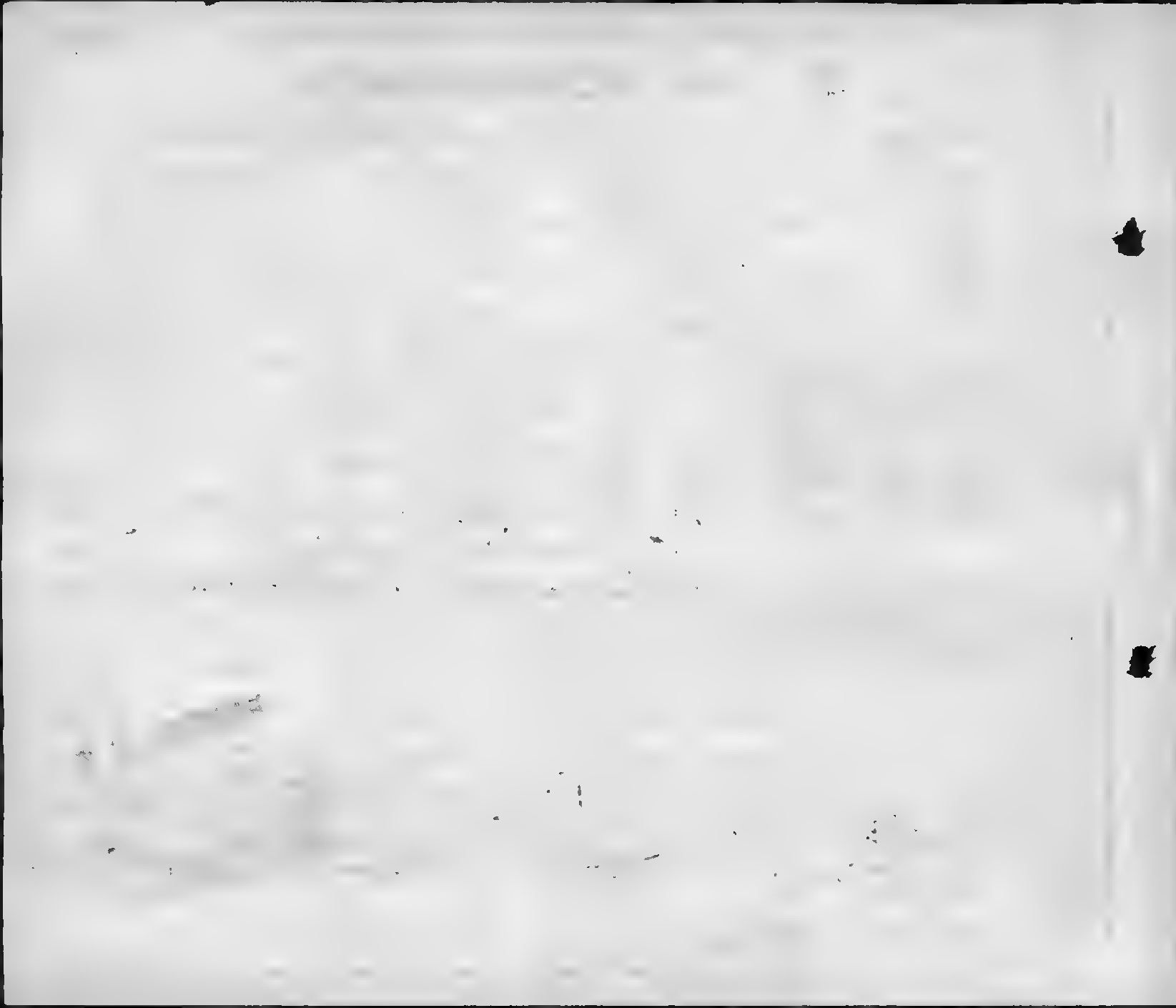
07382

7346

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Mo.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10 TOWN <u>ANNAPOHIS</u>				TOWN <u>ANNAPOHIS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>504 Sixth St.</u>				<u>504 Sixth St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>John H. Smith</u>				<u>8 4 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>		8. DATE OF BIRTH <u>7/13/1867</u>	
						9. AGE last birthday <u>88</u> yrs.	
						IF UNDER 1 YEAR	
						Months Days	
						IF UNDER 24 HRS	
						Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>CARPENTER CONSTRUCTION</u>				<u>CONSTRUCTION</u>		<u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>USA</u>				<u>John Smith</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			
<u>Mrs. Hargis W. Smith</u>				<u>No</u>			
16. SOCIAL SECURITY NO				17. INFORMANT & ADDRESS			
				<u>Mr. Hargis W. Smith #2</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				<u>Myocardial Infarction</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>2 days + 4 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1954</u> , to <u>Aug 4, 1955</u> , that I last saw the deceased alive on <u>Aug 4, 1955</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>James B. Math</u>		<u>8/5/55</u>		<u>Hill Crest</u>		<u>Annapolis, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>BURIAL</u>		<u>John M. Lyons</u>		<u>John M. Lyons</u>		<u>Annapolis</u>	
DATE <u>Aug 8, 1955</u>							



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 3100 9-13-55 ars

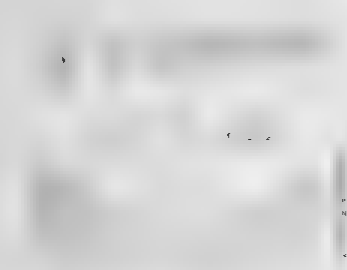
7392

CERTIFICATE OF DEATH

Reg. Dist. No.

07383

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL) <u>Bristol</u> LENGTH OF STAY (in this place)				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Friendship</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 416</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>Hamilton Crosby Stallings Jr</u>				4. DATE OF DEATH: (Month) <u>8</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Single</u>		8. DATE OF BIRTH: <u>March 10, 1914</u>	
9. AGE last birthday: <u>31</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Hamilton Crosby Stallings</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Bowen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT & ADDRESS: <u>Mr. Hamilton Stallings, Friendship</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
816 X IMMEDIATE CAUSE (A) <u>Collision & Fire</u> INTERVAL BETWEEN ONSET AND DEATH: <u>instantaneous</u>							
ANTECEDENT CAUSE (B) <u>Auto-Auto collision</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19A. DATE OF OPERATION: <u>8-29-55</u>				19B. MAJOR FINDINGS OF OPERATION <u>—</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				21B. PLACE (Home, farm, factory or highway street, office bldg., etc.) <u>Highway</u>			
21C. WHERE DID INJURY OCCUR? <u>Bristol AA</u> (State) <u>MD</u>							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>8-28-55</u> <u>3:00 A. M.</u>				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>Collision & Fire</u>			
22. I hereby certify that I attended the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased <u>alive on</u> <u>8-29-55</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hendricks</u> Acting Medical Examiner A.A. County <u>8-29-55</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>8/30/55</u> NAME OF CEMETERY OR CREMATORY <u>Friendship Ametery</u> LOCATION (City town, or county) <u>Friendship Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>8/30/55</u>				24. FUNERAL DIRECTOR <u>William H. Hutchins, Owings, Md.</u> ADDRESS			



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) Bristol
OR TOWN Bristol
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 416

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) Friendship
OR TOWN Friendship
STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED:

(First) Oscar (Middle) Bowen (Last) Stallings

4. DATE (Month) (Day) (Year)

OF DEATH: 8 28 1955

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Single

8. DATE OF BIRTH:

Oct 9, 1928

9. AGE last birthday

26 yrs

IF UNDER 1 YEAR IF UNDER 24 HRS

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

U. S. Navy

10. KIND OF BUSINESS OR INDUSTRY:

Seaman 1st C

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

Hamilton Crosby Stallings

14. MOTHER'S MAIDEN NAME

Myrtle Elizabeth Bowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk) (If Yes, give year or date of service)

yes April 1952

16. SOCIAL SECURITY NO.

Still Active

17. INFORMANT & ADDRESS

Mr Hamilton Stallings

Friendship

18. MEDICAL CERTIFICATION

DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

816X

IMMEDIATE CAUSE (A) Collision & Fire

ANTECEDENT CAUSE (B) Auto-Auto collision

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(C)

INTERVAL BETWEEN ONSET AND DEATH

instantaneous

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION.

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21a

21B. PLACE (Home, farm, factory, street, office bldg., etc.)

Highway

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

Bristol Anne A. Md.

21D. TIME (Month) (Day) (Year) (Hour) (Minute)

8-28-55 3:00 A M.

21E. INJURY OCCURRED While at work Not while at work

at work ☒ at work ☐

21F. HOW DID INJURY OCCUR?

Collision & Fire

22. I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased

alive on 19 and that death occurred at 3:00 P.M. from the causes and on the date stated above.

SIGNATURE

J. H. Hendricks, Acting Medical Examiner

ADDRESS

MD County

DATE SIGNED

8-29-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

8/30/55

NAME OF CEMETERY OR CREMATORY

Friendship Cemetery

LOCATION (City, town, or county)

Friendship, Md

(State)

DATE REC'D BY LOCAL REGISTRAR

8/30/55

REGISTRAR'S SIGNATURE

Eric W. Williams

24. FUNERAL DIRECTOR

W. H. Hatcher

ADDRESS

Owings, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



7394

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write OR and give nearest town)		RURAL LENGTH OF STAY (in this place)	
X TOWN <u>Pasadena</u>		45 yrs.		TOWN <u>Pasadena P.O.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Poplar Ridge Road, Poplar Ridge, Md.</u>				<u>Poplar Ridge Rd. Poplar Ridge</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(Type or Print) <u>Thomas</u>				(Month) (Day) (Year) <u>August 22 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>		8. DATE OF BIRTH: <u>April 29-1865</u>	
9. AGE last birthday: <u>90</u> yrs.		10. MONTHS: <u>90</u>		11. DAYS: <u>22</u>		12. HOURS: <u>19</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Kindy man</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Rope Boat yard</u>			
11. BIRTHPLACE (State or foreign country): <u>Baltimore Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>			
13. FATHER'S NAME: <u>P. - Tracey</u>				14. MOTHER'S MAIDEN NAME: <u>Marion Anne - P</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>No</u>				16. SOCIAL SECURITY No.: <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>Frank S. Tracey Pasadena P.O. Md.</u>							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>450.10</u> <u>Constrictive Heart Failure</u>							
Antecedent causes (s) (b) <u>generalized arteriosclerosis</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>none</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				22. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
PLACE (Home, farm, factory, street, office bldg., etc.)				(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED White at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>May 22, 1955</u> , to <u>August 22, 1955</u> , that I last saw the deceased alive on <u>August 21, 1955</u> , and that death occurred at <u>1:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. H. Singleton</u>				DATE SIGNED <u>August 22, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>Aug. 24-1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Marygrove Cemetery</u>				LOCATION (City, town or county) (State) <u>Marygrove, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>August 24, 1955</u>				REGISTRAR'S SIGNATURE <u>R. H. Singleton</u>			
24. FUNERAL DIRECTOR <u>Ben Barnes, Md.</u>							

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Henry

BUREAU V. S.

AUG 21 1879

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07386

7395

CERTIFICATE OF DEATH

Reg. Dist. No. 20

Items 2, 9, Film 185 9-1-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Ann Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A. A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Shoreham Beach</u>				OR TOWN <u>Edgewater</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				Route # <u>1, Box 399</u>			
3. NAME OF DECEASED (First) <u>ISABELLE</u> (Middle) (Last) <u>EVELYN ISABEL TUCKER</u> (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 22nd. 1955</u>			
5. SEX <u>F.</u>	6. CO. OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Feb 8th. 1898</u>		9. AGE last birthday <u>56' 57 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence Ricker</u>				14. MOTHER'S MAIDEN NAME <u>Isabel Binnix</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Chas E. Robertson</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
<u>153X</u> IMMEDIATE CAUSE (A) <u>Chronic disease of heart</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Heart failure</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Chronic disease of heart</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 25, 1955</u> to <u>Aug 25, 1955</u> that I last saw the deceased alive on <u>Aug 25, 1955</u> and that death occurred at <u>5 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u> M.D.				DATE SIGNED <u>Aug 25, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor Md 8/25/55</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Collins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. T. Collins</u>		ADDRESS <u>Wash. D.C.</u>	
DATE <u>Aug. 25, 1955</u>							

100-100000

AUG 2

100-100000

7347

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN Annapolis				TOWN Annapolis		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
12 Anne Arundel General				Spa Rd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) CHARLES (Middle) J (Last) VICKERS				(Month) AUGUST (Day) 21 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Male	White	Married	Feb. 14, 1901	54 yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Chauffeur		City Fire Dept		Baltimore, Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Minnie (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		no		Mrs Margaret Vickers- Wife- same as # 2			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				6 wks			
592X IMMEDIATE CAUSE (A) Uremia + Congestive failure							
ANTECEDENT CAUSE(S) DUE TO				4+ mos			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				4+ mos			
(B) Chronic nephritis							
(C) Hypertension							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
5/12/55		left pyonephrosis		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/20/55, 1955, to 5/21/55, that I last saw the deceased alive on 4/21/55, 1955, and that death occurred at 8 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Frank M. Shady				M.D. 63 College Ave Annapolis		9/2/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug 25, 1955		Cedar Bluff Cemetery		Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Aug. 25, 55		[Signature]		Hopping Funeral Home		Annapolis, Md	

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AISC 1-55 10M

PROB. V. S.

100

REC'D

MARYLAND

7348

07388

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

185 8-23-55 et

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>213 - Clay St Annapolis, Md</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> STREET ADDRESS <u>213 - Clay Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Alice</u> (First) (Middle) (Last) <u>White</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 14 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>December 25, 1902</u> 9. AGE last birthday <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>South Carolina USA</u>
13. FATHER'S NAME <u>James Pew</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Cama Weems</u>	
16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>(Husband) Paul White; 215 - Clay Street Annapolis, Md</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral Hemorrhage</u>		<u>Essential Hypertension</u>	<u>5 Months</u>
Antecedent cause(s) (b) <u>Essential Hypertension</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Essential Hypertension</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan 1955, to 8/14/55, that I last saw the deceased alive on 8/11/55, and that death occurred at 6:50 P.M. from the causes and on the date stated above.

SIGNATURE R. B. Ruckman ADDRESS M.D. 110 - Clay St Annapolis, Md DATE SIGNED 8/14/55

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 8-18-55 NAME OF CEMETERY OR CREMATORY Annapolis Neck LOCATION (City, town, or county) Annapolis Neck Md

DATE REC'D BY LOCAL REG. Aug. 17, 1955 REGIS. CLERK'S SIGNATURE [Signature] 24. FUNERAL DIRECTOR William Reese II 108 W. Wash. St. Annapolis, Md

MARGIN RESERVED FOR BINDING

WILLIAM A. S.

JUG 18 19

1950

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7396

CERTIFICATE OF DEATH

07389

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>1</u> <u>Malloryville</u>		<u>2 Months</u>		OR TOWN <u>303 Fifth Ave. North Cat. x</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Linda Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Glen Burnie</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Louise</u> (Middle) <u>Marie</u> (Last) <u>Widenhoff</u>				(Month) <u>August</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widow</u>		<u>Jan. 18, 1877</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>78</u> yrs.		<u>Housewife (R.D.)</u>		<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Herman J. Widenhoff</u>				<u>Justine C. Chavakovsky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>None</u>			
17. INFORMANT & ADDRESS				18. MEDICAL CERTIFICATION			
<u>Edwin R. Stallings</u>				<u>Town of Md.</u>			
19. DATE OF OPERATION				20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED			
				While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>7/8/55</u> , 19 <u>55</u> , to <u>8/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>55</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Guilford F. Fautsch</u>				<u>8/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. REC'D BY REGISTRAR			
<u>Burial</u>				<u>Lutherine M. Jeyap</u>			
25. FUNERAL DIRECTOR'S SIGNATURE				26. ADDRESS			
<u>Robt. Singleton</u>				<u>Glen Burnie</u>			
DATE <u>Aug 30 1955</u>							

S. A. OVERMAN

1884

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7397 CERTIFICATE OF DEATH

07390

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Crownsville</u>		4 yrs. 23 das.		TOWN <u>Baltimore</u>		3V-1-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>2504 Woodbrook Street</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Lewis Winston</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 1 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>4/8/86</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Winston</u>				14. MOTHER'S MAIDEN NAME <u>Mary Liza</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						6 hours	
422.1 IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>						Known to us since 7/9/51	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Insufficiency</u>						Known to us since 7/9/51	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/6</u> , 19 <u>55</u> , to <u>August 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/1</u> , 19 <u>55</u> , and that death occurred at <u>2:35</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Heidegard Heard Reimann</u>				ADDRESS (Street, city, town, state) <u>8/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>Aug. 3, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Catharine Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Aug 3, 1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Johnson</u>		ADDRESS <u>1700 Daniel Hill Ave.</u>	

2/1/52

Richard H. H. H. H.

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INSTRUCTIONS

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **7 days** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07391

7349 CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		COUNTY <u>Washington</u>		STATE <u>D.C.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington D.C.</u>		STREET ADDRESS (If rural, give location) <u>Annapolis Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel Gen.</u>				STREET ADDRESS <u>Annapolis Md</u>			
3. NAME OF DECEASED (Type or Print) <u>George Wright</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 27 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>5/11/1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>George</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO <u>049-07-5484</u>		17. INFORMANT & ADDRESS <u>Mary Wright</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
410X IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>						<u>2hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Mitral Stenosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>no</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/27/55</u> , 19... .., to... <u>8/27/55</u> , 19... .., that I last saw the deceased alive on... <u>8/27/55</u> , 19... .., and that death occurred at <u>5:29</u> P.M. from the causes and on the date stated above							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/31/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		LOCATION (City, town, of county) (State) <u>Arlington. V.A.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Therese H. Johnson M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH S. CORNISH-2121-105K</u>		ADDRESS <u>37 Cabot Street N.W.</u>	
DATE <u>Aug. 30, 1955</u>		SIGNATURE <u>Therese H. Johnson</u>		SIGNATURE <u>JOSEPH S. CORNISH</u>		ADDRESS <u>37 Cabot Street N.W.</u>	

License NO. 58. D.C.

N.W.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7350

CERTIFICATE OF DEATH

07392
21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>				TOWN <u>Annapolis</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>51 Lafayette Ave</u>				STREET ADDRESS (If rural give location) <u>51 Lafayette Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SAMUEL</u> (Middle) <u>ZEIKOWITZ</u> (Last)				(Month) <u>AUGUST</u> (Day) <u>26</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	April 3, 1871	84 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware store</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS <u>Mrs Sarah Zeikowitz- Wife- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>coronary occlusion</u>						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic heart disease</u>						15 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>diabetes mellitus</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> 19 <u>55</u> , to <u>Aug. 26</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 25</u> , 19 <u>55</u> , and that death occurred at <u>4:30 P.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Bommick</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>8/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>August 28, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Cemet.</u>		LOCATION (City, town, or county) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR <u>8-28-1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Annapolis, Md.</u>	

3 1/2 CENTS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7351 CERTIFICATE OF DEATH

07393

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AnneArundel</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>Monroe</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis, Maryland</u>		8mos.		TOWN <u>Rochester</u>		69X.3	
51 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Station Dispensary</u>				STREET ADDRESS (If rural give location) <u>1131 Bay Street</u> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Albert Eugene</u> (Middle) <u>ZETTLEMOYER</u> (Last)				(Month) <u>Aug.</u> (Day) <u>2</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Cauc.	Divorced	14 Dec. 1924	30 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
U.S. Navy			U.S. Navy		Williamsport, Penna		U.S.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Fred L. ZETTLEMOYER				Helen B. (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
Yes 11-6-42-8-2-55						Official Naval Records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema due to Heart Disease #434.2</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Co ronary Arteriosclerosis # 420.1</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> 19 <u>55</u> , to <u>1 Aug</u> 19 <u>55</u> , that I last saw the deceased alive on <u>1 Aug.</u> 19 <u>55</u> , and that death occurred at <u>0705 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W.T. Medic</u>				ADDRESS (Street, city, town, state) <u>U.S. Naval Station, Annapolis, Md.</u> DATE SIGNED <u>8-2-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		August 4, 55		to		Rochester, New York	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>August 4, 55</u>		<u>W.T. Medic</u>		<u>W.T. Medic</u>		<u>HOPPING FUNERAL HOME</u>	

DEATH CERTIFICATE

07503

THE STATE OF MASSACHUSETTS

BUREAU V. S.

AUG 5 1955

RECEIVED

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07394

7352 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>		<u>50 yrs.</u>		TOWN <u>Annapolis</u>		<u>10</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. Gen. Hosp.</u>				STREET ADDRESS (If rural give location) <u>96 East St.</u>			
3. NAME OF DECEASED (Type or Print) <u>OSCAR ANTON ZINDORF</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 28, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 11, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC Heating</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dayton, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH GILBERT ZINDORF</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE ANGEL BECK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-05-9592</u>		17. INFORMANT'S ADDRESS <u>MRS. FAY BASHAM 96 East St. Annapolis</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
148X IMMEDIATE CAUSE (A) <u>Hemorrhage internal</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of throat</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>March 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Cancer of throat</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 15, 1955</u> to <u>Aug 28, 1955</u> that I last saw the deceased alive on <u>Aug 28, 1955</u> and that death occurred at <u>8:25 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Jerse F. Wilkins</u> DATE SIGNED <u>8/28/55</u> ADDRESS <u>98 Cathedral St. Annapolis Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-31-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. RECEIVED BY REGISTRAR <u>John M. Saylor</u>		RECEIVED BY REGISTRAR'S SIGNATURE <u>John M. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>		ADDRESS <u>Annapolis Md</u>	
DATE <u>Aug 29, 1955</u>							

10-20-55

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

[Faint, mostly illegible handwritten text in the main body of the certificate, likely containing details of the deceased and the circumstances of death.]

BUREAU V. S.

AUG 30 1955

RECEIVED

[Faint handwritten notes and signatures at the bottom of the page, possibly indicating the registrar's signature and date.]

RECEIVED

[Vertical text on the right margin, likely a filing or processing stamp, mostly illegible.]